NAVIGATOR

by TUFTS Health Plan

Commonwealth of Massachusetts
Group Insurance Commission

> 2004 Member Handbook

Introduction

Welcome to Navigator by *Tufts Health Plan*™ ("Navigator") . We are pleased you have chosen this preferred provider organization (PPO) health plan. We look forward to working with you to help you meet your health care needs. This *Member Handbook* describes the **Navigator** health care plan.

Navigator is a self-funded plan, which means that the *Group Insurance Commission* (also referred to as "the *GIC"* or "Commission") is responsible for the cost of the *Covered Services* you receive under it. The *GIC* has contracted with *Tufts Health Plan*. Through *Tufts Health Plan,* Navigator offers you access to a network of health care professionals known as Tufts Health Plan ("Tufts HP") Providers and *Tufts HP* performs certain services, such as claims processing. *Tufts Health Plan* does not, however, insure plan benefits or determine your eligibility for benefits under the Navigator Plan.

This is a PPO plan, which means that you are not required to designate a primary care physician (PCP) and you are not required to get a referral for specialty services. This *Member Handbook* will help you find answers to your questions about your PPO benefits.

Navigator *Members* have benefits for *Covered Services* according to the terms of this *Member Handbook*. The Plan covers your medical and prescription drug benefits. Your EAP/Mental Health and Substance Abuse benefits are administered by United Behavioral Health (UBH).

Medical and Prescription Drug Plan - *Tufts Health Plan* administers Navigator, which provides the medical and prescription drug benefits described in this *Member Handbook.* Navigator *Members* are encouraged to receive all health care services from the *Tufts Health Plan* network of health care *Providers*. Using these *Tufts HP Providers* will minimize a *Member's* out-of-pocket expenses for *Covered Services*. To find out which *Providers* are in the network, you can either:

- look in the Navigator *Directory of Health Care Providers*;
- call the Member Services Department at 1-800-870-9488; or
- check out the *Tufts Health Plan* web site at **www.tuftshealthplan.com**.

For ***Outpatient*** **medical care**, *Covered Services* provided by a *Tufts HP Provider* are covered at the *In-Network Level of Benefits*. *Covered Services* that are not provided by a *Tufts HP Provider* are covered at the *Out-of-Network Level of Benefits* (see pages 21-23).

Inpatient **hospital stays** at *Tufts HP Hospitals* for *Obstetric Services*, *Pediatric Services*, or *Adult Medical and Surgical Services* are grouped into *Inpatient* Hospital *Copayment* Levels based on the quality and efficiency each hospital delivers for each of these types of services (see Part 3, pages 21-22, for more information about the standards used for grouping the hospitals). Hospitals that provide better quality and efficiency are grouped in *Copayment* Level 1 and require a **$200** *Copayment*. Hospitals that provide good quality and efficiency are grouped in *Copayment* Level 2 and require a **$400** *Copayment* for *Inpatient* admissions. Please see "Benefit Overview" (pages 10-17) and "Plan and Benefit Information" (pages 18-20) for further details on your coverage and costs for medical services under this Plan.

Prescription drug benefits that are available and the requirements that each *Member* needs to follow in order to obtain these benefits are described in Part 5 (see pages 48-52).

Please note that italicized words have special meanings. These meanings are given in the "Definitions" section (see Part 9, pages 66-72).

EAP/Mental Health and Substance Abuse Plan – This plan is administered by United Behavioral Health (UBH). You and your covered family *Members* are automatically eligible for a full range of confidential and professional Enrollee Assistance Program (EAP), mental health and substance abuse services that are administered by UBH. Legal, family mediation and financial counseling services, grief counseling, and referrals to self-help groups and child or elder care services are among the many services available through the UBH EAP. For mental health or substance abuse services or in an emergency, UBH can help you access a conveniently located network Provider. UBH benefit information is located on pages 79-92 of this booklet.

Members must present their Navigator member identification card (member ID) to *Providers* when they receive *Covered Services* in order for benefits to be administered properly. Each member ID contains the following information:

- instructions for accessing in-network benefits;
- the toll-free telephone number to call when *Emergency* Care or *Urgent Care* is needed; and
- the toll-free telephone number to call for *United Behavioral Health*-related services.

The Member Services Department is committed to excellent service. Your satisfaction with Navigator is important to us. If at any time you have questions, please call the Member Services Department which will be happy to help you. Calls to the Member Services Department may be monitored by supervisors to assure quality service.

Tufts Health Plan Address And Telephone Directory

TUFTS HEALTH PLAN
333 Wyman Street
P.O. Box 9112
Waltham, Massachusetts 02454-9112
Hours: Monday – Thursday 8:00 a.m. to 7:00 p.m. E.S.T.
Friday 8:00 a.m. to 5:00 p.m. E.S.T.

IMPORTANT PHONE NUMBERS:

Emergency Care

If you are experiencing an *Emergency*, you should seek care at the nearest *Emergency* facility. If needed, call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for emergency medical services.

For routine care, you should always call your physician before seeking care. If you have an urgent medical need and cannot reach your physician, you should seek care at the nearest emergency room.

Liability Recovery

Call the Coordination of Benefits (COB) Department at 1-888-880-8699, extension 1098 for questions about coordination of benefits and workers' compensation. For example, call the COB Department if you have any questions about how *Tufts Health Plan* (*Tufts HP*) coordinates coverage with other health care coverage that you may have. The COB Department is available from 8:30 a.m. – 5:00 p.m. Monday through Thursday and from 10:00 – 5:00 p.m. on Friday.

For questions related to subrogation, call the Member Services Department at 1-800-870-9488. If you are uncertain which department can best address your questions, call Member Services.

Member Services Department

Call the Member Services Department at 1-800-870-9488 for general questions, benefit questions, and information regarding eligibility for enrollment and billing.

Services for Hearing Impaired *Members*

If you are hearing impaired, the following services are provided:

Massachusetts Relay (MassRelay)

1-800-720-3480 Telecommunications Device for the Deaf (TDD)

If you have access to a TDD phone, call 1-800-815-8580 or 1-800-868-5850 to reach the Member Services Department.

IMPORTANT ADDRESSES:

Appeals and Grievances Department

If you need to call *Tufts HP* about a concern or appeal, contact the Member Services Department at 1-800-870-9488. To submit your appeal or grievance in writing, send your letter to:

Tufts Health Plan
Attn: Appeals and Grievances Department
705 Mount Auburn Street
P.O. Box 9193
Watertown, MA 02471-9193

Web site

For more information about *Tufts Health Plan* and to learn more about the self-service options that are available to you, please see the *Tufts Health Plan* Web site at **www.tuftshealthplan.com**.

Translating Services

Translating services for 140 languages
Interpreter and translator services related to administrative procedures are available to assist *Members* upon request. For information, please call the Member Services Department.

خدمات المترجمين والترجمة المتعلقة بالاجراءات الادارية متوفرة لمساعدتك في هذا الشأن. لطلب هذه الخدمات، الرجاء الاتصال بقسم علاقات الزبون التابع لخطة "تفتس هلس بلان".

អ្នកបកប្រែភាសា និងកិច្ចការបកប្រែទាំងឡាយ ដែលជាប់ទាក់ទងនឹងទំរង់ការខាងការចាត់ចែងការ គឺមានផ្តល់សំរាប់ជួយអ្នក ។ ដើម្បីស្នើសុំការបំពើទាំងនេះ សូមទូរស័ព្ទមកក្រសួងទំនាក់ទំនងភ្ញៀវ នៃគំរោងថែរក្សាសុខភាពរបស់ Tufts ។

相關管理程序的口譯和筆譯服務隨時爲您提供協助。如需要這些服務，請打電話給「Tufts 健康計劃顧客聯絡部」。

Des services d'interprétariat et de traduction liés aux procédures administratives sont disponibles. Pour demander ces services, veuillez contacter le département des relations avec la clientèle de Tufts Health Plan.

Για την εξυπηρέτησή σας, υπάρχουν διαθέσιμες υπηρεσίες ερμηνείας και μετάφρασης σχετικά με τις διοικητικές διαδικασίες. Για να ζητήσετε αυτές τις υπηρεσίες, τηλεφωνήστε στο Τμήμα Πελατειακών Σχέσεων του Προγράμματος Ιατροφαρμακευτικής Ασφάλισης Tufts.

ພວກເຮົາມີບໍລິການນາຍພາສາແລະການແປເອກະສານທາງດ້ານວິທີດຳເນີນການຫຸລະການໄວ້ ບໍລິການທ່ານ. ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຂອງແຜນສຸຂະພາບທັຟສ Tufts , ຖ້າຕ້ອງການບໍລິການເຫລົ່ານີ້.

Temos disponíveis serviços de tradução e interpretação relacionados aos procedimentos administrativos. Para obter estes serviços, ligue para o departamento de relações com o cliente do Tufts Health Plan.

С целью оказать Вам помощь по административным процедурам предлагаются устные и письменные переводческие услуги. Если Вам нужны эти услуги, позвоните, пожалуйста, в Отдел связей с клиентами Плана здравоохранения «Тафтс» Tufts.

Los servicios de traducción e interpretación en relación a procedimientos administrativos están disponibles para ayudarle. Para solicitar este servicio, favor de llamar al departamento de relaciones con el cliente de Tufts Health Plan.

Genyen sèvis tradiksyon ak entèprèt disponib pou ede ou nan zafè ki gen rapò ak jan administrasyon an fè sèvis li. Pou ou mande sèvis sa yo, tanpri rele depatman sèvis kliyan Tufts Health Plan.

1-800-870-9488

TDD Telecommunications Device for the Deaf: 1-800-868-5850 or 1-800-815-8580

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NAVIGATOR

by TUFTS Health Plan

Medical and Prescription Drug Benefits

Part 1 - Benefit Overview

Do not rely on this chart alone. It merely summarizes certain important benefits available to Navigator *Members*. **Be sure to read the benefit explanations in Part 5 (see pages 34-52)**. They describe *Covered Services* in more detail and contain some important restrictions. Remember, in order to receive In-Network *Covered Services*, you must receive care from a *Tufts HP Provider*.

Deductibles and Maximums

	In-Network	Out-of-Network
	***Member's* Cost**	***Member's* Cost**
Office Visit *Copayment* Maximum (*In-Network Level of Benefits* only)	A $15 *Copayment* applies to the first 15 In-Network office visits a *Member* receives each calendar year. Then for the rest of that year, the $15 *Copayment* is waived for those *Covered Services*. This Office Visit *Copayment* Maximum does not apply to office visits for spinal manipulation.	Not applicable.
***Day Surgery Copayment* Maximum (*In-Network Level of Benefits* only)** ☞ Page 18	Four *Day Surgery Copayments* of $75 per procedure apply for each individual *Member* per calendar year. Once the *Day Surgery Copayment* Maximum is reached in a calendar year, *Member* is not responsible for any additional *Day Surgery Copayments* for the remainder of the year.	Not applicable.
***Inpatient* Care *Copayment* Maximum (*In-Network Level of Benefits* only)** ☞ Page 18	One *Inpatient Copayment* ($200 per admission at a Level 1 hospital ; $400 per admission at a Level 2 hospital) applies for each individual *Member* per calendar quarter (for example, January through March). Once this *Inpatient Copayment* Maximum is reached in a calendar quarter, *Member* is not responsible for any additional *Inpatient Copayments* for the remainder of the calendar quarter.	Not applicable.
***Deductible*:** ☞ Page 19	None	$150 per *Member* each calendar year. (Each of two *Members* must satisfy a *Member Deductible* per *Family Plan*.)
Out-of-Network *Out-of-Pocket Maximum*: ☞ Page 20	Not applicable	$3,000 per *Member* each calendar year. ($150 *Deductible* counts toward this *Out-of-Pocket Maximum*)

Continued on next page

Covered Services	**In-Network**	**Out-of-Network**
	***Member's* Cost**	***Member's* Cost**
Emergency Care		
• Treatment in an *Emergency* room ☞ Page 35	$50 *Copayment* (waived if admitted as an *Inpatient*)	$50 *Copayment* (waived if admitted as an *Inpatient*)
• Treatment for an *Emergency* in a physician's office ☞ Page 35	$15 *Copayment* **A *Member* must call *Tufts Health Plan* at 1-800-870-9488 within 48 hours after if he or she is admitted as an *Inpatient* after *Emergency* Care is received in order to be covered at the *In-Network Level of Benefits*.**	$15 *Copayment*

***Outpatient Care*:**		
Cardiac rehabilitation ☞ Page 35	$15 *Copayment*	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Coronary Artery Disease Program ☞ Page 36	10% of the *Reasonable Charge*.	Full cost. This is not covered at the *Out-of-Network Level of Benefits*.
Diabetes self-management training and educational services ☞ Page 36	$15 *Copayment*	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Early intervention services ☞ Page 36	**Covered up to a total of $3,200 per *Member* each calendar year ($9,600 lifetime) (In-Network and Out-of Network Levels combined)** $15 *Copayment*	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Family planning procedures, services, and contraceptives ☞ Page 36	$15 *Copayment*	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)

Continued on next page

Covered Services	**In-Network**	**Out-of-Network**
	***Member's* Cost**	***Member's* Cost**
***Outpatient* Care, continued:**		
Hemodialysis ☞ Page 37	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Infertility services (up to five completed impregnation procedures) **(AR)** ☞ Page 37	Covered in full, except for office visits, for which a $15 *Copayment* per visit applies.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Maternity care (includes prenatal & postpartum care) ☞ Page 38	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
***Outpatient* medical care**		
Allergy testing ☞ Page 38	$15 *Copayment*.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Chemotherapy ☞ Page 38	$15 *Copayment.*	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Cytology screening (Pap Smear) - one annual screening ☞ Page 38	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Diagnostic x-rays and lab services ☞ Page 38	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Human leukocyte antigen testing ☞ Page 38	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Mammography screenings ☞ Page 38	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Medically Necessary diagnosis and treatment of speech, hearing and language disorders (includes speech therapy) **(AR)** ☞ Page 38	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the In-Network and Out-of-Network Levels of Benefits.

Continued on next page

Part 1 - Benefit Overview, Continued

Covered Services	In-Network *Member's* Cost	Out-of-Network *Member's* Cost
***Outpatient* Care, continued:**		
***Outpatient* medical care, continued**		
Nutritional counseling ☞ Page 39	$15 *Copayment*.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Office visits ☞ Page 39	$15 *Copayment*	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Outpatient surgery in a physician's office ☞ Page 39	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Radiation therapy and x-ray therapy ☞ Page 39	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Voluntary second or third surgical opinions ☞ Page 39	$15 *Copayment*	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Patient care services provided as part of a qualified clinical trial (for treatment of cancer) ☞ Page 39	$15 *Copayment*	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Preventive health care - Adults (age 18 and over) (includes annual routine gynecological exam, hearing exams, and routine eye exam – see page** for more information on these benefits and their limits) ☞ Page 39	$15 *Copayment*	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Preventive health care - *Children* (under age 18) ☞ Page 39	$15 *Copayment*	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Short-term physical & occupational therapy services **(AR)** ☞ Page 40	$15 *Copayment*	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the In-Network and Out-of-Network Levels of Benefits.

Continued on next page

Covered Services	**In-Network**	**Out-of-Network**
	***Member's* Cost**	***Member's* Cost**
Oral health services		
Oral surgery for dental treatment **(AR)** ☞ Page 40	<u>*Day Surgery*</u>: $75 *Copayment* per person per *Day Surgery* admission, up to the *Day Surgery Copayment* Maximum described below. <u>*Inpatient* care</u>: Applicable *Inpatient* care *Copayment* (see "*Inpatient* Care" below).	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Emergency care ☞ Page 40	<u>Treatment in an *Emergency* room</u>: $50 *Copayment* (waived if admitted as an *Inpatient*). <u>Treatment in a physician's office</u>: $15 *Copayment*.	<u>Treatment in an *Emergency* room</u>: $50 *Copayment* (waived if admitted as an *Inpatient*). <u>Treatment in a physician's office</u>: $15 *Copayment*.
Oral surgical procedures for non-dental medical treatment **(AR)** ☞ Page 40	<u>Office visit</u>: $15 *Copayment*. <u>*Day Surgery*</u>: $75 *Copayment* per person per *Day Surgery* admission, up to the *Day Surgery Copayment* Maximum described below. <u>*Inpatient* care:</u> Applicable *Inpatient* care *Copayment* (see "*Inpatient* Care" below).	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)

***Day Surgery*:**		
Day Surgery ☞ Page 40	*$75 Copayment per person per Day Surgery admission, up to the Day Surgery Copayment Maximum described on page 10 above.*	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the In-Network and Out-of-Network Levels of Benefits.

Continued on next page

Covered Services	**In-Network**	**Out-of-Network**
	***Member's* Cost**	***Member's* Cost**
***Inpatient* Care:**		
Acute hospital services (including room and board, physician services, surgery, and related services) ☞ Page 41	***COPAYMENT* LEVELS:** *Copayment* Level 1 ($200) or *Copayment* Level 2 ($400) for *Inpatient* care up to the *Inpatient* Care *Copayment* Maximum described on page 18. See Part 11 on pages 75-78 for the Navigator *Inpatient* Hospital *Copayment* Levels	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Bone Marrow Transplants for Breast Cancer and Human Organ Transplants **(AR)** ☞ Page 41		*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Maternity care (hospital and delivery services, and also well Newborn care in Hospital) ☞ Page 42		*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Patient care services provided as part of a qualified clinical trial (for treatment of cancer) ☞ Page 42		*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Reconstructive surgery and procedures **(AR)** ☞ Page 42		*Deductible* & 20% of the *Reasonable Charge* (plus any balance) **The *Member* is required to preregister any Out-of-Network hospital admission, or must pay a $500 Preregistration Penalty for that admission.**

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the In-Network and Out-of-Network Levels of Benefits.

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Covered Services	**In-Network**	**Out-of-Network**
	***Member's* Cost**	***Member's* Cost**
Other Health Services:		
Ambulance services ☞ Page 43	Covered in full.	Covered in full.
Extended care facility services in: ▪skilled nursing facility; ▪rehabilitation hospital; or ▪chronic hospital. ☞ Page 43	Covered in full. • **Covered facility and physician services in a skilled nursing facility are limited to a combined total of $10,000 per *Member* in a calendar year (In-Network and Out-of-Network Levels combined).** • **Preregistration is required prior to any Out-of-Network admission, or the *Member* must pay a $500 Preregistration Penalty (see pages 27-29).**	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Home health care **(AR)** ☞ Page 44	Covered in full. **All home health care treatment plans must be authorized by an *Authorized Reviewer*.**	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Hospice care ☞ Page 44	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Injectable medications **(AR)** ☞ Page 45	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Medical appliances and equipment: ▪Durable Medical Equipment (including *Prosthetic Devices*) **(AR)** ☞ Page 45	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
▪Eyeglasses/contact Lenses (only the first pair after cataract surgery) ☞ Page 45	Covered in full.	20% of the *Reasonable Charge* (not subject to the *Deductible*)
▪Hearing aids ☞ Page 45	**The first $500 is covered in full. Then, 20% of the next $1,500 (plus any balance) (In-Network and Out-of-Network Levels combined).** **Limited to a total of one hearing aid per *Member* every two calendar years (In-Network and Out-of-Network Levels combined).**	

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the In-Network and Out-of-Network Levels of Benefits.

Continued on next page

Covered Services	In-Network	Out-of-Network
	***Member's* Cost**	***Member's* Cost**
Other Health Services, continued:		
Personal Emergency Response System (only hospital-based) ☞ Page 46	20% up to: ▪$50 for installation; ▪$40 per month for rental. (plus any balance)	
Private duty nursing care (*Inpatient* and *Outpatient*) ☞ Page 46	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
	Covered up to a total of $8,000 per *Member* in a calendar year (In-Network and Out-of-Network Levels combined).	
Special Medical Formulas		
Low protein foods ☞ Page 46	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
	Covered up to a total of $2,500 per *Member* in a calendar year (In-Network and Out-of-Network Levels combined).	
Nonprescription enteral formulas ☞ Page 47	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Special medical formulas ☞ Page 47	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Spinal manipulation ☞ Page 47	$15 *Copayment**.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
	Limited to a total of 20 visits per calendar year (In-Network and Out-of-Network Levels combined). *This benefit is not subject to the Office Visit *Copayment* Maximum described above. You pay $15 *Copayment* per visit up to the 20-visit benefit limit.	

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the In-Network and Out-of-Network Levels of Benefits.

Prescription Drug Benefit

For information about your *Copayments* for covered prescription drugs, see the "Prescription Drug Benefit" section in Part 5 (see pages 48-52).

EAP/Mental Health & Substance Abuse Services (see pages 79-94):

Benefits administered by United Behavioral Health.
For information, call: 1-888-610-9039

Your Cost for Medical Services

You are responsible for paying the costs described below for *Covered Services* you receive at the In-Network and Out-of-Network Levels of Benefits. For more information about the *Covered Services* subject to these costs, please see Part 5.

In-Network Level of Benefits

Covered Services are covered at the *In-Network Level of Benefits* only when the *Covered Services* are provided by a *Tufts HP Provider*.

If a *Covered Service* is not available from a *Tufts HP Provider*, as determined by *Tufts Health Plan*, with *Tufts Health Plan's* approval you may receive *Covered Services* at the *In-Network Level of Benefits* from a non-Tufts HP Provider up to the *Reasonable Charge*.

Copayments

- *Emergency* Care (In-Network and Out-of-Network Levels of Benefits):
  - *Emergency* room ..... $50 per visit.
  - In physician's office ..... $15 per visit.
- *In-Network Level of Benefits*:
  - Office Visit ..... $15 per visit*.
  - *Inpatient* Services ..... Varies by service and hospital chosen; see Part 11.
  - *Day Surgery* ..... $75 per procedure.

*You only pay Office Visit *Copayments* for a maximum of 15 visits per year. Subsequent visits are covered in full.

***Day Surgery Copayment* Maximum (*In-Network Level of Benefits* Only)**

Members are responsible for paying four *Day Surgery Copayments* per calendar year.

The *Day Surgery Copayment* Maximum is the most money you will have to pay for *Day Surgery* in a calendar year. This Maximum consists of in-network *Day Surgery Copayment*s only. It does not include *Deductibles*, *Coinsurance*, other *Copayments* or payments you make for non-*Covered Services*. When the *Copayment* Maximum is reached, no more *Day Surgery Copayments* will be charged in that calendar year.

***Inpatient* Care *Copayment* Maximum (*In-Network Level of Benefits* Only)**

Members are responsible for paying one *Inpatient Copayment* (Level 1 or Level 2) per calendar quarter (for example, January through March) for a maximum of four *Copayments* in a calendar year. This maximum consists of in-network *Inpatient* care *Copayments*.

The *Inpatient* Care *Copayment* Maximum is the most money you will have to pay for Inpatient care in a calendar year. This maximum consists of in-network *Inpatient* care *Copayments* only. It does not include *Deductibles*, *Coinsurance*, other *Copayments*, or payments you make for non-*Covered Services*. Once this *Inpatient Copayment* Maximum is reached in a calendar quarter, the *Member* is not responsible for any additional *Inpatient Copayments* until the following calendar quarter (in other words, at most four *Copayments* per calendar year).

Out-of-Network Level of Benefits

Covered Services are covered at the *Out-of-Network Level of Benefits* when they are not provided by a *Tufts HP Provider*. These *Covered Services* are subject to a *Deductible* and *Coinsurance*, and are covered at a lower level than *Covered Services* provided at the *In-Network Level of Benefits*.

Note: Each time you receive care at the *Out-of-Network Level of Benefits*, you must submit a claim form to *Tufts Health Plan*. For more information, contact the Member Services Department. (You are not required to submit claim forms for care you receive from *Tufts HP Providers*.)

Coinsurance **(In-Network and Out-of-Network Levels of Benefits)**

- ***In-Network Level of Benefits***:
  There is no *Coinsurance* for most *Covered Services* provided by a *Tufts HP Provider*. Except as shown in Part 1 (see "Benefit Overview" on pages 10-17), the *Member* pays the applicable *Copayment* for all *Covered Services* provided by a *Tufts HP Provider*. The *Plan* will cover the remaining charges for *Covered Services*.

- ***Out-of-Network Level of Benefits***:
  Except as shown in Part 1 (see "Benefit Overview" on pages 10-17), the *Member* pays 20% *Coinsurance* for all *Covered Services* provided by a Non-*Tufts HP Provider*. The *Plan* will cover the remaining charges for *Covered Services*, up to the *Reasonable Charge*. (The *Member* is responsible for any charges in excess of the *Reasonable Charge*.)

Individual *Deductible* (*Out-of-Network Level of Benefits* Only)

A $150 *Deductible* applies to each *Member* each calendar year for all *Covered Services* you receive at the *Out-of-Network Level of Benefits*. This is the amount you must first pay for *Covered Services* before the Navigator *Plan* will pay for any *Covered Services* at the *Out-of-Network Level of Benefits*.

If you receive *Covered Services* during the last three months of a calendar year, the amount you pay for those *Covered Services* that could be used to satisfy all or any portion of this *Deductible* may also be used to satisfy this *Deductible* for the next calendar year.

Family *Deductible* (*Out-of-Network Level of Benefits* Only)

A $300 Family *Deductible* applies each calendar year for all *Covered Services* obtained at the *Out-of-Network Level of Benefits*. This is how the Family *Deductible* works:

Two separate enrolled *Members* of a covered family must each satisfy his or her $150 Individual *Deductible* during a calendar year. Once this occurs, the rest of the covered *Members* of that family will not need to satisfy any *Deductible* for the remainder of that calendar year.

If the covered members of a family receive *Covered Services* during the last three months of a calendar year, the amount those family members pay for those *Covered Services* that could be used to satisfy all or any portion of this Family *Deductible* may also be used to satisfy this Family *Deductible* for the next calendar year.

Note: The out-of-network *Deductible* does not apply to:

1. *Outpatient Emergency* care and *Urgent Care* you receive in a hospital *Emergency* room.
2. Personal Emergency Response Systems (PERS).
3. Hearing aids.
4. The first pair of eyeglass lenses (eyeglass frames are not covered) and/or contact lenses needed after cataract surgery.
5. *Covered Services* in connection with the Coronary Artery Disease Program.

***Out-of-Pocket Maximum* (*Out-of-Network Level of Benefits* Only)**

A $3,000 Individual *Out-of-Pocket Maximum* applies to you each calendar year for *Covered Services* you receive at the *Out-of-Network Level of Benefits*.

The only charges that satisfy this *Out-of-Pocket Maximum* are the *Deductible* and *Coinsurance* for *Covered Services* obtained at the *Out-of-Network Level of Benefits*. Once you satisfy the Individual *Out-of-Pocket Maximum* in a calendar year, all *Covered Services* you receive at the *Out-of-Network Level of Benefits* are covered in full up to the *Reasonable Charge* for the rest of that year.

Note: You cannot use the following services and supplies to satisfy this *Out-of-Pocket Maximum*:

1. Any service or supply that does not qualify as a *Covered Service*. This includes any services that require the approval of an *Authorized Reviewer* prior to treatment for which you do not obtain such approval.
2. Any amount that you must pay for a Covered Out-of-Network Service when the actual charges for the service exceed the *Reasonable Charge*.
3. Any amount you pay for a Personal Emergency Response System (PERS).
4. Any amount you pay for spinal manipulation.
5. The amount you pay as a Preregistration Penalty or any other reduction or denial of benefits when you fail to preregister when required under the Navigator Plan. See pages 27-29 for more information.
6. Any *Copayment* or other amount you pay for In-Network *Covered Services*.
7. Any amount you pay for *Covered Services* in connection with the Coronary Artery Disease Program.

Preregistration Penalty

You must pay the Preregistration Penalty listed below for failure to preregister a hospitalization or hospital transfer in accordance with Part 3.

- ***In-Network Level of Benefits*:**
  There is no Preregistration Penalty for an In-Network hospitalization or an In-Network hospital transfer. Your *Tufts HP Provider* will preregister the procedure for you.

- ***Out-of-Network Level of Benefits***:
  You must pay a $500 Preregistration Penalty for failure to preregister a hospitalization or hospital transfer at the *Out-of-Network Level of Benefits* in accordance with Part 3. For more information, please see "Preregistration" in Part 3 (pages 27-29).

Note: This Preregistration Penalty cannot be used to meet the *Deductibles* or *Out-of-Pocket Maximums* described earlier in this section.

How the *Plan* Works

Eligibility for Benefits
When you need health care services, you may choose to obtain these services from either a *Tufts HP Provider* (*In-Network Level of Benefits*) or a non-*Tufts HP Provider* (*Out-of-Network Level of Benefits*). Your choice will determine the level of benefits you receive for your health care services.

The Plan covers only the services and supplies described as *Covered Services* in Part 5. There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your *Effective Date*.

> **Important Note:** *Inpatient* hospital *Copayments* are based on the hospital's quality and efficiency. See "*Inpatient* Care" below for more information.

***Medically Necessary* services and supplies**
The *Plan* will pay for *Covered Services* and supplies when they are *Medically Necessary*, as determined by *Tufts Health Plan*. *Covered Services* must be provided by a *Tufts HP Provider* to be covered at the *In-Network Level of Benefits*. *Covered Services* provided by any non-*Tufts HP Provider* will be covered at the *Out-of-Network Level of Benefits*.

Important: The Navigator Plan will not pay for services or supplies which are not *Covered Services*, even if they are provided by a *Tufts HP Provider* or any other *Provider*.

In-Network Level of Benefits

***Outpatient* Care**
If your care is provided by a *Tufts HP Provider*, you are entitled to coverage for *Covered Services* at the *In-Network Level of Benefits*. You are not required to designate a primary care physician (PCP); instead, you can choose to see any *Tufts HP Provider* to receive care at the *In-Network Level of Benefits*. When a *Tufts HP Provider* provides your care, you do not have to submit any claim forms. The claim forms are submitted to *Tufts Health Plan* by the *Tufts HP Provider*.

You pay a *Copayment* for certain *Covered Services* performed by Tufts HP Providers. For more information about your costs for medical services, see "Benefit Overview" and "*Plan* and Benefit Information" earlier in this *Member Handbook*.

***Inpatient* Care**
The Navigator Plan offers two *Copayment* Levels for *Inpatient* hospital stays at *Tufts HP Hospitals* for *Obstetric Services*, *Pediatric Services*, or *Adult Medical and Surgical Services*. *Copayments* vary based on which hospital you choose and on what type of services you receive.

Hospitals that offer better quality and efficiency are grouped in *Copayment* Level 1. **You will be charged a $200 *Copayment* for *Inpatient Obstetric Services*, *Pediatric Services*, or *Adult Medical and Surgical Services* at a hospital that is in *Copayment* Level 1 for the type of service you receive.**

Hospitals that offer good quality and efficiency are grouped in *Copayment* Level 2. **You will be charged a $400 *Copayment* for *Inpatient Obstetric Services*, *Pediatric Services*, or *Adult Medical and Surgical Services* at a hospital that is in *Copayment* Level 2 for the type of service you receive.**

Part 11 provides a list of the *Tufts HP Hospitals* and their *Copayment* Levels for the above services.

Important Note: Some *Tufts HP Hospitals* and services are not grouped in the *Copayment* Levels. These include:

- hospitals that primarily provide specialty services, including the Dana Farber Cancer Institute, the Massachusetts Eye and Ear Infirmary, and the New England Baptist Hospital (a $400 *Copayment* applies per admission to these hospitals);
- hospitals with fewer than 100 admissions for *Obstetric Services* or *Pediatric Services* (a $400 *Copayment* per admission applies for these services at these hospitals – see Part 11, pages 75-78);
- *Tufts HP Hospitals* that are located outside of Massachusetts (a $400 *Copayment* applies per admission to these hospitals); and
- Covered transplant services for *Members* at our In-Network Transplant Centers of Excellence (a $200 *Copayment* applies for these services).

In addition, there are other services that are not included under these *Copayment* Levels. These include *Day Surgery*; certain care for newborn *Children*; and rehabilitation, extended care, and skilled nursing services at a skilled nursing facility, rehabilitation hospital, or chronic care facility. For information about your costs and limits for these services, please see "Benefit Overview" and Part 11 in this *Member Handbook*.

If you have questions or want more information about the hospital grouping process, please contact the Navigator PPO Member Services Department.

Selecting a *Provider*

In order to receive coverage at the *In-Network Level of Benefits*, you must receive care from a *Tufts HP Provider* listed in the *Directory of Health Care Providers*.

Notes:

- Under certain circumstances, if your physician is not in the *Tufts Health Plan* network, you will be covered for a short period of time at the *In-Network Level of Benefits* for services provided by your physician. The Member Services Department can give you more information. Please see "Continuity of Care" on page 23.
- For additional information about a *Tufts HP Provider*, the Massachusetts Board of Registration in Medicine provides information about physicians licensed to practice in Massachusetts. You may reach the Board of Registration at (617) 727-0773 or **www.massmedboard.org.**

No Preregistration by You

As long as your *Inpatient* procedure is provided by a *Tufts HP Provider*, you are not responsible for preregistering the procedure. Your *Tufts HP Provider* will preregister the procedure for you. See "Preregistration" on pages 27-29 for more information.

Canceling Appointments

If you have to cancel an appointment with any *Tufts HP Provider*, always give him or her as much notice as possible, but at least 24 hours. If the *Tufts HP Provider's* office policy is to charge for missed appointments that were not canceled in advance, you will have to pay the charges. The *Plan* will not pay for missed appointments that you did not cancel in advance.

Changes to the *Tufts Health Plan Provider* network

Tufts Health Plan offers *Members* access to an extensive network of physicians, hospitals, and other *Providers* throughout the *Service Area*. Although *Tufts Health Plan* works to ensure the continued availability of *Tufts HP Providers*, our network of *Providers* may change during the year.

This can happen for many reasons, including a *Provider's* retirement, moving out of the *Service Area*, or failure to continue to meet *Tufts Health Plan's* credentialing standards. In addition, because *Providers* are independent contractors who do not work for *Tufts Health Plan*, this can also happen if *Tufts Health Plan* and the *Provider* are unable to reach agreement on a contract.

If you have any questions about the availability of a *Provider*, please call the Member Services Department.

Out-of-Network Level of Benefits

Out-of-Network Level of Benefits

If your care is not provided by a *Tufts HP Provider*, you are entitled to coverage for *Covered Services* at the *Out-of-Network Level of Benefits*. You pay a *Deductible* and *Coinsurance* for certain *Covered Services* you receive at the *Out-of-Network Level of Benefits*. For more information about your *Member* costs for medical services, see "*Plan* and Benefit Information" at the front of this *Member Handbook*.

Please note that you must submit a claim form for each service that is provided by a non-*Tufts HP Provider*. For information on filing claim forms, see Part 6.

Covered Services* Not Available from a *Tufts HP Provider

If *Tufts Health Plan* determines that a *Covered Service* is not available from a *Tufts HP Provider*, , with *Tufts Health Plan's* approval, you may go to a non-*Tufts HP Provider* and receive *Covered Services* at the *In-Network Level of Benefits* up to the *Reasonable Charge*.

Preregistration by You

If you receive *Inpatient* services from a non-*Tufts HP Provider*, you must preregister these services. If you do not preregister, you will be subject to a Preregistration Penalty. See "Preregistration" on pages 27-29 for more information.

Continuity of Care

If you are an existing *Member*

If your *Provider* is involuntarily disenrolled from *Tufts Health Plan* for reasons other than quality or fraud, you may continue to see your *Provider* to obtain *Covered Services* at the *In-Network Level of Benefits* in the following circumstances:

- *Pregnancy*. If you are in your second or third trimester of pregnancy, you may continue to see your *Provider* through your first postpartum visit.
- *Terminal Illness*. If you are terminally ill, you may continue to see your *Provider* until your death.

If you are enrolling as a new *Member*

When you enroll as a *Member*, if none of the health plans offered by the *GIC* includes your *Provider*, you may continue to see your *Provider* if:

- you are undergoing a course of treatment. In this instance, you may continue to see your *Provider* for *Covered Services* and receive the *In-Network Level of Benefits* for up to 30 days from your *Effective Date*.
- you are in your second or third trimester of pregnancy. In this instance, you may continue to see your *Provider* to obtain *Covered Services* at the *In-Network Level of Benefits* through your first postpartum visit.
- you are terminally ill. In this instance, you may continue to see your *Provider* to obtain *Covered Services* at the *In-Network Level of Benefits* until your death.

Conditions for coverage of continued treatment

Tufts Health Plan may condition coverage of continued treatment for *Covered Services* at the *In-Network Level of Benefits* upon the *Provider's* agreement:

- to accept reimbursement from *Tufts Health Plan* at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to a *Member* in an amount that would exceed the cost sharing that could have been imposed if the *Provider* has not been disenrolled;
- to adhere to the quality assurance standards of *Tufts Health Plan* and to provide *Tufts HP* with necessary medical information related to the care provided; and

- to adhere to *Tufts Health Plan's* policies and procedures, including obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by the *Tufts HP*.

Emergency Care

To Receive *Emergency* Care
If you are experiencing an *Emergency*, you should seek care at the nearest *Emergency* facility. If needed, call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for emergency medical services.

***Outpatient Emergency* Care**
If you receive *Emergency* services but are not admitted as an *Inpatient*, the services will be covered at the *In-Network Level of Benefits*. You will be required to pay a *Copayment* for each *Emergency* room visit.

***Inpatient Emergency* Care**
If you receive *Emergency* services and are admitted as an *Inpatient* (in either a *Tufts HP Hospital* or a *non-Tufts HP Hospital*), you or someone acting for you must notify *Tufts Health Plan* within 48 hours of seeking care in order to be covered at the *In-Network Level of Benefits*. (Notification from the attending physician satisfies this requirement.) Otherwise, coverage for these services will be provided at the *Out-of-Network Level of Benefits*.

Also, if you are admitted as an *Inpatient* to a hospital that is a non-*Tufts HP Provider*, you must preregister the admission within 48 hours after you are admitted for *Inpatient Emergency* care or you will be charged a $500 Preregistration Penalty. Preregistration guidelines are described on pages 27-29.

Financial Arrangements between *Tufts Health Plan* and *Tufts HP Providers*

Methods of payment to *Tufts HP Providers*
Tufts Health Plan's goal in compensating *Providers* is to encourage preventive care and active management of illnesses. *Tufts Health Plan* strives to be sure that the financial reimbursement system we use encourages appropriate access to care and rewards providers for taking the best care of our *Members*. *Tufts Health Plan* uses a variety of mutually agreed upon methods to compensate *Tufts HP Providers*.

The *Directory of Health Care Providers* indicates the method of payment for each *Provider*. Regardless of the method of payment, *Tufts Health Plan* expects all participating *Providers* to use sound medical judgment when providing care and when determining whether a referral for specialty care is appropriate. This approach encourages the provision of *Medically Necessary* care and reduces the number of unnecessary medical tests and procedures which can be both harmful and costly to *Members*.

Tufts Health Plan reviews the quality of care provided to *Members* through its Quality of Health Care Program. You should feel free to discuss specific questions about how he or she is paid with your *Provider*.

Member Identification Card

Introduction
Each *Member* receives a member identification card (member ID).

Reporting errors
Call the Member Services Department.

Using your card
Your member ID is important because it identifies your health care plan. Please remember to:

- carry your card at all times;
- have your card with you for medical, hospital and other appointments; and
- show your card to any *Provider* before you receive health care.

Member Identification Card, continued

Receiving services
When you receive services from a *Tufts HP Provider*, bring your member ID card with you and be sure to identify yourself with the office staff as a Navigator *Member*. If you do not do this, the *Covered Services* you receive from that *Tufts HP Provider* may be covered at the *Out-of-Network Level of Benefits*.

Membership requirement
You are eligible for benefits if you are a *Member* when you receive care. A member ID alone is not enough to receive benefits. If you receive care when you are not a *Member*, you are responsible for the cost.

Membership identification number
If you have any questions about your member identification number, please call the Member Services Department.

Utilization Management

Introduction
This section describes the Plan's utilization management program.

Utilization management
Tufts HP has a utilization management program. The purpose of the program is to evaluate whether health care services provided to *Members* are *Medically Necessary* and provided in the most appropriate and efficient manner. Under this program, *Tufts Health Plan* sometimes uses prospective, concurrent, and retrospective review of health care services.

Tufts Health Plan uses **prospective review** to determine whether proposed treatment is *Medically Necessary* before that treatment begins. For example, *Tufts Health Plan* will not cover any *Inpatient* hospital admissions or hospital transfers unless its Preregistration Department has been notified of those health care services in advance. See "Preregistration" later in Part 3 for more information about the *Plan's* preregistration requirements.

Tufts Health Plan uses **concurrent review** to monitor the course of treatment as it occurs and to determine when that treatment is no longer *Medically Necessary*.

Retrospective review is used to evaluate care after the care has been provided. In some circumstances, *Tufts Health Plan* uses retrospective review to determine more accurately the appropriateness of health care services provided to *Members*.

Tufts HP makes coverage determinations. You and your *Provider* make all treatment decisions.

IMPORTANT NOTE: *Members* can call the Member Services Department at 1-800-870-9488 to determine the status or outcome of utilization review decisions.

Specialty case management
Some *Members* with severe illnesses or injuries may warrant case management intervention under *Tufts Health Plan's* specialty case management program. Under this program, *Tufts Health Plan*

- encourages the use of the most appropriate and cost-effective treatment; and
- supports the *Member's* treatment and progress.

The *Member* and his or her *Tufts HP Provider* may be contacted to discuss a treatment plan and establish short and long term goals. A Specialty Case Manager may suggest alternative treatment settings available to the *Member*.

Tufts Health Plan may periodically review the *Member's* treatment plan. The *Member* and the *Member's Tufts HP Provider* will be contacted if alternatives to the *Member's* current treatment plan are identified that:

- qualify as *Covered Services*;
- are cost effective; and
- are appropriate for the *Member*.

A severe illness or injury includes, but is not limited to, the following:

- high-risk pregnancy and newborn *Children*;
- serious heart or lung disease;
- cancer;
- certain neurological diseases;
- AIDS or other immune system diseases;
- certain mental health conditions, including substance abuse;
- severe traumatic injury.

Individual case management (ICM)
In certain circumstances, *Tufts Health Plan* may authorize an individual case management ("ICM") plan for a *Member* with a severe illness or injury. The ICM plan is designed to arrange for the most appropriate type, level, and setting of health care services and supplies for the *Member*.

As a part of the ICM plan, the *Plan* may authorize coverage for alternative services and supplies that do not otherwise constitute *Covered Services* for that *Member*. This will occur only if the *Plan* determines that all of the following conditions are satisfied:

- the *Member's* condition is expected to require medical treatment for an extended duration;
- the alternative services and supplies are *Medically Necessary*;
- the alternative services and supplies are in lieu of more expensive treatment that qualifies as *Covered Services*;
- the *Member* and an *Authorized Reviewer* agree to the alternative treatment program; and
- the *Member* continues to show improvement in his or her condition, as determined periodically by an *Authorized Reviewer*.

When *Tufts Health Plan* authorizes an ICM plan, the *Plan* will also indicate the *Covered Service* that the ICM plan will replace. The benefit available for the ICM plan will be limited to the benefit that the *Member* would have received for the *Covered Service*.

Tufts Health Plan will periodically monitor the appropriateness of the alternative services and supplies provided to the *Member*. If, at any time, these services and supplies fail to satisfy any of the conditions described above, the Plan may modify or terminate coverage for the services or supplies provided pursuant to the ICM plan.

Preregistration

Preregistration
Preregistration is *Tufts Health Plan's* process of prior authorization for all *Inpatient* hospital admissions and transfers. A review team will verify your eligibility at that time and assign an anticipated length-of-stay guideline for an approved hospital admission.

In certain cases, the review team will also
- evaluate your proposed medical care;
- verify whether that care is *Medically Necessary*; or
- recommend an alternative treatment.

Important note about preregistration
Preregistration does not guarantee that the *Plan* will cover the health care services you receive. The *Plan* is not obligated to cover any services or supplies that have been preregistered for any person who:
- is not a *Member* on the date services are provided;
- fails to meet other eligibility rules;
- receives services or supplies that are not *Covered Services*; or
- receives care that is not *Medically Necessary*, as determined by *Tufts Health Plan*.

When Covered Services are provided by a *Tufts HP Provider*
When a *Tufts HP Provider* is directing your care, he or she is responsible for preregistering your *Inpatient* admission or transfer. In this case, you do not need to preregister the admission or transfer.

When Covered Services are not provided by a *Tufts HP Provider*
When your care is not provided by a *Tufts HP Provider*, you are responsible for preregistering any *Inpatient* admission or transfer.

Important: If you do not preregister, you will be required to pay a $500 Preregistration Penalty for the care you receive in addition to the *Deductible* and *Coinsurance*. Please carefully read the following description of the preregistration process that you must complete when a *Tufts HP Provider* is not directing your care.

How to Preregister

You must call *Tufts Health Plan* at 1-800-870-9488 to preregister your care. The Preregistration Department is available Monday through Friday between 8:30 a.m. and 5:00 p.m. to accept preregistration information.

You, or someone acting on your behalf, will be asked to provide the following information:
- the patient name, address, and phone numbers (work and home);
- the *Member's* identification number (from your member ID);
- the admitting physician's name, address, and phone number;
- the admitting hospital's name, address, and phone number;
- the *Member's* diagnosis and proposed procedure; and
- the proposed admission and discharge dates.

How to Preregister, continued

When to preregister when care is not provided by a Tufts HP Provider
You must preregister for the following services within the following time limits:

- For elective hospital admissions or transfers: You must preregister at least seven (7) days prior to hospitalization. After you call the Preregistration Department, *Tufts Health Plan* will consult with your physician and then:
  - notify you or your physician of its preregistration determination, including the anticipated length-of-stay guidelines; or
  - recommend alternative treatment.

- For a hospital admission for *Urgent Care* - You must preregister immediately before you are admitted as a hospital *Inpatient*. An urgent admission is one which requires prompt medical intervention but one in which there is a reasonable opportunity to preregister prior to, or at the time of, admission.

- For a hospital admission for *Emergency* care - You or someone acting on your behalf must preregister within 48 hours after you are admitted as a hospital *Inpatient*.

- For maternity care for delivery of a newborn *Child* - Once you know the due-date for delivery of your newborn *Child*, you may preregister your delivery at any time prior to your due-date.

- For *Inpatient* hospital care for a newborn *Child* - You must preregister your newborn *Child*:

  - following a vaginal delivery, when the newborn *Child* remains as a hospital *Inpatient* for more than 48 hours after birth; or

  - following a cesarean delivery, when the newborn *Child* remains as a hospital *Inpatient* for more than 96 hours after birth.

  Note: If your newborn *Child* is a hospital *Inpatient* for less than 48 hours after birth, you do not need to preregister *Inpatient* hospital care for that *Child*.

Preregistration Penalty
You must preregister your *Inpatient* hospital admission or transfer for Out-of-Network care, as described above. If you fail to meet any of the requirements for preregistration described in this Part 3, you must pay a $500 Preregistration Penalty. This Preregistration Penalty is in addition to any *Deductible* and *Coinsurance* that you are required to pay for that care.

After you preregister
After you call the Preregistration Department with the required information, your physician or the hospital will be notified of the decision made by the review team.

Changes to preregistration information
Preregistration is valid only for the diagnosis, procedure, admission date, and medical facility specified at the time of preregistration. You must notify *Tufts Health Plan* about any delays, changes, or cancellations of your proposed hospital admission.

You must obtain a separate preregistration for
- a new date for your hospital admission;
- readmission or a new admission as a hospital *Inpatient*; or
- transfer to another facility.

Important: You must notify *Tufts Health Plan* about these changes before your hospital admission begins. If you fail to do this, you will be required to pay a $500 Preregistration Penalty for that admission.

Preregistration, continued

Extending *Inpatient* hospital care
You or someone acting for you (for example, your physician) may contact *Tufts Health Plan* to request an extension of your *Inpatient* hospital care beyond the length of stay initially authorized by *Tufts Health Plan*.

Tufts Health Plan will review your request to extend your *Inpatient* hospital care. As a part of this review, you may be asked to provide additional information about your medical condition. If *Tufts Health Plan* determines that an extension of your *Inpatient* hospital care is *Medically Necessary*, additional hospital days may be authorized for you.

Important: *Tufts Health Plan* may determine that your *Inpatient* hospital care is no longer *Medically Necessary*. In this case, *Tufts Health Plan* will notify you that:

- The *Plan* will **not** pay for any additional hospital days; and
- you will be responsible for paying all hospital and physician charges, if you choose to remain as a hospital *Inpatient* beyond the length of stay initially authorized by *Tufts Health Plan*.

Enrollment

When to enroll
As a *Subscriber*, you may enroll yourself and your eligible *Dependents*, if any, for this coverage. Enrollment is subject to the provisions of Massachusetts General Laws, Chapter 32A, the *GIC* Rules and Regulations, and applicable federal law.

With respect to federal law, please note that you may enroll yourself and your eligible *Dependents*, if any, for this coverage only:

- during the *Annual Enrollment Period*;
- within 10 days of the date you (the *Subscriber*) are first eligible for this coverage; or
- within 31 days of the date your *Dependent* is first eligible for this coverage.

Note: If you fail to enroll for this coverage when first eligible, you may be eligible to enroll yourself and your eligible *Dependents*, if any, at a later date. This will apply only if you:

- declined this coverage when you were first eligible because you or your eligible *Dependent* was covered under another group health plan or other health insurance coverage at that time; or
- declined this coverage when you were first eligible, and you have acquired a *Dependent* through marriage, divorce, birth, adoption, or placement for adoption.

In these cases, you or your eligible *Dependent* may enroll for this coverage within 31 days after any of the following events:

- your coverage under the other health coverage ends involuntarily;
- your marriage or divorce; or
- the birth, adoption, or placement for adoption of your *Dependent Child*.

Effective Date

***Effective Date* of coverage**

Coverage begins on the first day of the month following the lesser of:

- sixty (60) days or two (2) calendar months of employment;
- the July 1st following the *Annual Enrollment Period* when this health care program is selected; or
- the date determined by the *GIC* for a late enrollment.

Adding *Dependents*

Introduction
This section explains how a *Subscriber* may add new *Dependents* under a *Family Plan*. After you enroll as a *Subscriber*, you may apply to enroll any eligible *Dependents* who are not currently enrolled in the Navigator Plan. This process will work as described below.

***Spouse* and/or Unmarried *Dependent Children* Under Age 19**
- A *Spouse* and all eligible *Dependent Children* (under age 19) must enroll under a *Family Plan* in order to ensure coverage.
- *Subscribers* who are active employees enrolled under an *Individual Plan* must apply to their *GIC* Coordinator for a *Family Plan*. *Subscribers* who are retired employees must send a written request for a *Family Plan* to the *GIC*.
- *Members* already enrolled under a *Family Plan* on the date of marriage should notify their *GIC* Coordinator (if employed by the state) or the *GIC* (if retired) and provide a copy of the marriage certificate if the *Member* wishes to add the *Spouse*.

Newborn *Children*
Coverage for a newborn *Child* who is a natural *Child* will become effective on the *Child's* date of birth, provided that:
- *Members* enrolled under an *Individual Plan* arrange for a *Family Plan* by notifying the *GIC* Coordinator at their worksite. The *GIC* must receive a written request to change the membership to a *Family Plan* not more than thirty-one (31) days after the *Child's* date of birth.
- *Members* already enrolled under a *Family Plan* when the *Child* is born must notify their *GIC* Coordinator within thirty-one (31) days after the *Child's* date of birth that the new *Dependent Child* must be added to the membership.

Note: For more information, see "Additional Information About Newborn *Children*" on page 32.

Adoptive Children
A *Child* who is a legally adopted *Dependent Child* must be enrolled under a *Family Plan* within thirty-one (31) days after the adoption or placement for adoption in order to ensure coverage for that *Child*. Active employees enrolled under an *Individual Plan* must arrange for a *Family Plan* by notifying the *GIC* Coordinator at their worksite. Retirees must notify the *GIC* in writing.

Student Dependents
Coverage is available under a *Family Plan* for an unmarried *Dependent Child* who is a full-time Student at the age of 19 and enrolled in an accredited educational institution. *Members* must apply to the *Plan* for *Student Dependent* Coverage. The *Plan* requires verification of full-time student status from the accredited educational institution for any *Member* enrolled as a *Student Dependent* under a *Family Plan*. The *Plan* will request this verification information from the *Subscriber*.

Note: Failure to recertify coverage when required will result in termination of Student coverage. See "When Coverage Ends" below for more information.

Handicapped Child
Coverage is available under a *Family Plan* for a *Handicapped Child* who is age 19 or older, provided that the *Child* was either mentally or physically handicapped so as not to be capable of earning his or her own living on the date he or she reached age 19. Special arrangements must be made with the *GIC* for the Disabled *Child* to continue coverage.

Children* of Unmarried *Dependent Children
Coverage is available for the *Children* of unmarried *Dependent Children* who are enrolled under a *Family Plan*. Coverage for the *Dependent's Child* will become effective on the *Child's* date of birth, provided that the *GIC* is notified in writing not more than thirty-one (31) days after the date of birth that the *Child* of the unmarried *Dependent Child* must be added to the *Family Plan*.

Adding *Dependents*, continued

Former *Spouses* (in the event of remarriage)
Generally, coverage for the former *Spouse* ends if either party remarries. A former *Spouse* who is enrolled under a *Family Plan* may be able to continue coverage under the *Family Plan* in the event of divorce or legal separation. Contact the *GIC* for information about continuation of coverage in this circumstance.

***Members* Age 65 and Eligible for Medicare**
Coverage is available under this *Plan* only until the first day of the month in which a retired *Member* turns 65 years of age and becomes eligible to enroll in the Medicare Program (Part A and B). The *Subscriber* (or *Spouse* and/or *Dependent Children*) will have the option of continuing coverage under this *Plan* when the *Subscriber* remains as an actively working employee after reaching age 65.

Additional Information About Newborn *Children*

Care at the *In-Network Level of Benefits*
The *Plan* will cover your newborn *Child* from birth at the *In-Network Level of Benefits* for *Covered Services* for *Routine Nursery Care* and other *Medically Necessary* care, when:

- the *Subscriber* enrolls the newborn *Child* within 31 days after birth;
- the newborn *Child's* care is obtained from a *Tufts HP Provider*.

Care at the *Out-of-Network Level of Benefits*
The Navigator Plan will cover your newborn *Child* from birth at the *Out-of-Network Level of Benefits* for *Routine Nursery Care* and other *Medically Necessary* care when the *Subscriber* enrolls the newborn *Child* within 31 days after birth and the newborn *Child's* care is not obtained from a *Tufts HP Provider*.

If the *Subscriber* does not enroll the newborn *Child* within 31 days after birth, the Navigator Plan will only cover that newborn *Child* at birth for an initial 31-day period. During this period, the Navigator Plan will only cover the newborn *Child* at the *Out-of-Network Level of Benefits* and will only cover *Routine Nursery Care* for:

- up to 48 hours, in the case of a vaginal delivery; and
- up to 96 hours, in the case of a caesarean delivery.

To continue coverage for the newborn *Child* after this 31-day period, the *Subscriber* must apply to enroll the *Child* by contacting the *GIC* Coordinator at his or her worksite (if employed) or the *GIC* (if retired).

When Coverage Ends

Subscribers

Active employee *Subscribers* may terminate their coverage in the *Plan* by providing prior written notice to the *GIC* Coordinator at their worksite. Retired *Subscribers* may terminate their coverage in the *Plan* by sending their written request to the *GIC*.

Otherwise, this *Plan* will end when:

- A *Subscriber* is no longer eligible for health care coverage with the *GIC* (for example, the hours are reduced to less than half-time or the *Subscriber* leaves the job). In this case, coverage under this health care program ends at the end of the month following the month during which he or she loses eligibility.
- A *Subscriber* stops paying his or her share of the cost of this health care program. In this case, coverage ends at the end of the period covered by his or her last contribution payment.
- A *Subscriber* reaches age 65, becomes eligible for Medicare and retires (or is already retired). Contact the *GIC* for more information about the options to continue health care coverage.
- the *GIC* ends this health care program.

Spouse and/or *Dependent Children*

Coverage for a *Spouse* and/or *Dependent Children* enrolled under a *Family Plan* will end when:

- The *Subscriber's* coverage ends, as described in the provision captioned "*Subscribers*" above.
- At the end of the month in which the *Dependent Child* reaches age 19, unless he or she:
  - is unmarried and enrolled as a full-time Student and has had his or her application for *Student Dependent* coverage approved; or
  - is a *Handicapped Child*, as determined by the *GIC*.
- The *Dependent Child* marries.
- The divorced *Spouse* is no longer eligible for coverage under this health care program.
- The *Spouse* reaches age 65 and becomes eligible for Medicare, unless the *Subscriber* remains an active employee and this *Plan* remains the family's primary coverage.

In any of the situations described above, coverage under this *Plan* ends when the *Spouse* and/or *Dependent Children* lose their eligibility under this *Plan*.

Student Dependents

Coverage for *Student Dependents* enrolled under a *Family Plan* will end when he or she:

- turns age 24**;
- discontinues or withdraws from full-time classes;
- graduates; or
- marries.

****Important Note:** If the *Student Dependent* turns age 24 and is still a full-time student, he or she may continue under the *Subscriber's* coverage by paying an additional full cost individual premium. The *Student Dependent* can remain under the Subscriber's coverage until he or she:

- discontinues or withdraws from full-time classes;
- fails to pay the required premium contribution;
- fails to recertify *Student Dependent* eligibility with the *GIC* when required;
- graduates; or
- marries.

In any of the situations described above, coverage under this health care program ends at the end of the month during which the *Student Dependent* loses his or her eligibility under the *Plan*.

Covered Services

When health care services are *Covered Services*
Health care services and supplies are *Covered Services* only if they are:

- listed as *Covered Services* in this Part 5;
- *Medically Necessary*, as determined by *Tufts Health Plan*;
- consistent with applicable law;
- provided to treat an injury, illness or pregnancy, except for preventive care; and
- approved by an *Authorized Reviewer*, in some cases.

Important Notes

- Certain *Covered Services* require the prior approval of an *Authorized Reviewer* at both the In-Network and *Out-of-Network Level of Benefits* (see "Benefit Overview" to determine which services require this prior approval).
  - If you receive these services from a *Tufts HP Provider (In-Network Level of Benefits)*, that *Provider* is responsible for obtaining approval from *Tufts Health Plan*.
  - If you receive these services from a non-*Tufts HP Provider (Out-of-Network Level of Benefits)*, you are responsible for obtaining prior approval from *Tufts HP*. If prior approval is not received, the Navigator Plan will not cover those services and supplies.
- Preregistration: You must preregister Out-of-Network *Inpatient* services. Please see "Preregistration" in Part 3 (pages 27-29) for more information.
- All claims for services (whether or not the services were provided by a *Tufts HP Provider*) are subject to retrospective review by an *Authorized Reviewer*. *Authorized Reviewers* review claims to be sure that the claims are for *Covered Services*. A *Covered Service* is one that is described in Part 5. Only claims that are for *Covered Services* will be paid by the *Plan*.

YOUR COSTS FOR *COVERED SERVICES*:

- For information about your costs for the *Covered Services* listed below, (for example, *Copayments*, *Coinsurance*, and *Deductibles*), see the "Benefit Overview" starting on page 10.
- Information about the day, dollar, and visit limits under this plan is listed in the "Benefit Overview" starting on page 10 and in certain *Covered Services* listed below.

Emergency Care

- Care for an *Emergency* in an *Emergency* room;
- Care for an *Emergency* in a physician's office.

Notes:

- The *Emergency* Room *Copayment* is waived if the *Emergency* room visit results in an immediate hospitalization.
- If you receive *Emergency Covered Services* from a non-*Tufts HP Provider*, the *Plan* will pay up to the *Reasonable Charge*. You pay the applicable *Copayment* and any difference between what the *Plan* paid and what the non-*Tufts HP Provider* charged for the service.

***Outpatient* care**

Cardiac rehabilitation

Services for *Outpatient* treatment of documented cardiovascular disease that:

- meet the standards promulgated by the Massachusetts Commissioner of Public Health, and
- are initiated within 26 weeks after diagnosis of cardiovascular disease.

The *Plan* covers only the following services:

- the *Outpatient* convalescent phase of the rehabilitation program following hospital discharge; and
- the *Outpatient* phase of the program that addresses multiple risk reduction, adjustment to illness and therapeutic exercise.

Notes:

- Once treatment has been initiated, the *Member* can receive covered cardiac rehabilitation services for up to 6 months from the date of the first visit.
- For *Members* with *angina pectoris*, only one course of cardiac rehabilitation services will qualify as *Covered Services*.
- The *Plan* does not cover the program phase that maintains rehabilitated cardiovascular health.

Contraceptives – See "Family Planning Procedures, Services, and Contraceptives" on page 36.

Outpatient Care - continued

Coronary Artery Disease Program
The Coronary Artery Disease secondary prevention program is designed to assist you in making necessary lifestyle changes that can reduce your cardiac risk factors.

Note: This program is available at designated programs when *Medically Necessary* to *Members* with documented Coronary Artery Disease who meet the clinical criteria established for this program.

For more information about this program, *Members* should call the Member Services Department.

Diabetes self-management training and educational services
Outpatient self-management training and educational services, including medical nutrition therapy, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes.

Important Notes:
- *Tufts Health Plan* will only cover these services when provided by a *Tufts HP Provider* who is a certified diabetes health care provider.
- Medical nutritional therapy provided under this benefit is not subject to any visit limit described in the "Nutritional counseling" benefit on page 39.

Early intervention services for a *Dependent Child*
Services provided by early intervention programs that meet the standards established by the Massachusetts Department of Public Health. Early intervention services include:
- occupational therapy;
- physical therapy;
- speech therapy;
- nursing care; and
- psychological counseling.

These services are available to *Members* from birth until their third birthday.

Note: Early intervention services are covered up to a total of $3,200 per calendar year, and a lifetime maximum of $9,600.

Family planning procedures, services, and contraceptives

Family planning procedures
- tubal ligation;
- sterilization; and
- pregnancy termination.

Family planning services
- medical examinations;
- birth control counseling; and
- genetic counseling.

Contraceptives
The following contraceptives are available, when provided by a physician and administered in that physician's office:
- Cervical caps;
- IUDs;
- Levonorgestrel (Norplant®);
- Depo-Provera*.

*Notes:
- Please note that *Tufts HP* covers certain contraceptives, such as oral contraceptives and diaphragms, under your Prescription Drug Benefit. If those contraceptives are covered under that benefit, they are not covered here.
- Also, please note that, in certain circumstances, Depo-Provera is covered under the Prescription Drug Benefit instead of this "Contraceptives" benefit. For more information, see page 49.

Outpatient care – continued

Hemodialysis

- *Outpatient* hemodialysis; and
- *Outpatient* peritoneal dialysis.

Note: Benefits for home hemodialysis also qualify as a *Covered Service*, but only when provided under the direction of a general or chronic disease hospital or free-standing dialysis facility.

Infertility services (must be approved by an *Authorized Reviewer*)

Diagnosis and treatment of Infertility* in accordance with applicable law.

Note: Oral and injectable drug therapies used in the treatment of infertility associated with the *Covered Services* below are considered *Covered Services* only when the *Member* has been approved for associated infertility services. See your Prescription Drug Benefit section for your *Copayment* amounts.

Infertility services include:

(I.) the following services and supplies provided in connection with an infertility evaluation (not subject to *Authorized Reviewer* approval):

- diagnostic procedures and tests;
- artificial insemination (intrauterine or intracervical) when performed with non-donor (partner) sperm.

(II.) the following procedure when approved in advance by an *Authorized Reviewer*:

- artificial insemination (intrauterine or intracervical) when performed with donor sperm.

Note: Donor sperm is only covered when the partner has a diagnosis of male factor infertility.

(III.) the following Assisted Reproductive Technology ("ART") procedures when approved in advance by an *Authorized Reviewer***:

- in-vitro fertilization and embryo transfer;
- G.I.F.T. (gamete intra-fallopian transfer);
- Z.I.F.T. (zygote intra-fallopian transfer);
- I.C.S.I. (intracytoplasmic sperm injection);
- N.O.R.I.F. (natural ovulation intravaginal fertilization);
- banking, procurement, and processing of sperm, eggs, or embryos when associated with active infertility treatment

**Note: These ART procedures will only be considered *Covered Services* for *Members* with Infertility:

- who meet *Tufts Health Plan's* eligibility requirements, which are based on the *Member's* medical history;
- who meet the eligibility requirements of *Tufts Health Plan's* contracting infertility Services providers; and
- with respect to the procurement and processing of donor sperm, eggs, or embryos, to the extent such costs are not covered by the donor's health care coverage, if any.

Coverage for Assisted Reproductive Technology (ART) is provided only when *Medically Necessary* and is subject to approval in advance by an *Authorized Reviewer* at both the In-Network and Out-of-Network Levels of Benefits (see "Important Notes" on page 34 of Part 5 for more information about when you are responsible for obtaining this approval). ART services are provided up to a maximum of 5 attempts. Exceptions will be made only when *Tufts Health Plan* determines the services to be *Medically Necessary*.

*Infertility is defined as the involuntary condition of a presumably otherwise healthy *Member* who has regularly attempted but has been unable to conceive or produce conception during a period of one year.

Outpatient **Care – continued**

Maternity Care

- Prenatal care, exams, and tests; and
- postpartum care provided in a physician's office.

Outpatient **medical care**

- Allergy testing (including antigens) and treatment.

  Note: Allergy treatment (for example, an allergy shot) provided to you at the *In-Network Level of Benefits* is subject to an Office Visit *Copayment* when received as part of an office visit. However, there may not be a *Copayment* if the sole purpose of your visit is to receive allergy treatment (for example, an allergy shot).

- Chemotherapy.

- Cytology screening (Pap Smear) - one annual screening for women age 18 and older;

- Diagnostic laboratory tests including, but not limited to, glycosolated hemoglobin (A1c) tests and urinary protein/microalbumin and lipid profiles;

- Human leukocyte antigen testing or histocompatibility locus antigen testing for use in bone marrow transplantation when necessary to establish a *Member's* bone marrow transplant donor suitability. Includes costs of testing for A, B or DR antigens; or any combination consistent with the rules and criteria established by the Department of Public Health.

- Mammography screenings at the following intervals:
  - one baseline at 35-39 years of age,
  - one every year at age 40 and older,
  - or as otherwise *Medically Necessary*;

- *Medically Necessary* diagnosis and treatment of speech, hearing and language disorders (services may require the approval of an *Authorized Reviewer*). These services include speech therapy.

***Outpatient* care – continued**

Outpatient* medical care *(continued)

- Nutritional counseling, when given outside of an approved home health care plan. Covered up to a total of 3 visits per calendar year.

  Notes:

  - This visit limit does not apply to *Outpatient* nutritional counseling provided as part of:
    - an approved home health care plan (see "Home health care" benefit on page 44); or
    - diabetes self-management training and educational services (see benefit on page 36).
  - Must be authorized by an *Authorized Reviewer*.
- Office visits to diagnose and treat illness or injury.
- *Outpatient* surgery in a physician's office.
- Radiation therapy and x-ray therapy.
- Voluntary second or third surgical opinions.

Patient care services provided as part of a qualified clinical trial

As required by Massachusetts law, patient care services provided as part of a qualified clinical trial for the treatment of cancer are covered to the same extent as those *Outpatient* services would be covered if the *Member* did not receive care in a qualified clinical trial.

Preventive health care – Adults (age 18 and over)

- Routine physical examinations, including appropriate immunizations and lab tests as recommended by the physician.
- Immunizations and lab tests, when not rendered as part of a routine physical exam.
- Routine gynecological exams, including any follow-up obstetric or gynecological care determined to be *Medically Necessary* as a result of that exam.
- *Medically Necessary* evaluations and related health care services for acute or *Emergency* gynecological conditions
- Hearing examinations and screenings.
- One routine eye exam in each 24-month period.

Preventive health care – *Children* (under age 18)

- preventive care services from the date of birth until age 18, including:
  - physical examination,
  - history,
  - measurements,
  - sensory screening,
  - neuropsychiatric evaluation, and
  - developmental screening and assessment at the following intervals:
    - birth until age 6 months - 6 visits;
    - age 6 months until age 18 months - 6 visits;
    - age 18 months until age 3 - 6 visits;
    - age 3 until age 18 - 1 visit per calendar year.
- Coverage is also provided for:
  - hereditary and metabolic screening at birth;
  - appropriate immunizations and tuberculin tests;
  - hematocrit, hemoglobin, or other appropriate blood tests;

- urinalysis as recommended by the physician; and
- newborn auditory screening tests, as required by state law.

Outpatient **care – continued**

Short term physical and occupational therapy services (services may require the approval of an *Authorized Reviewer*)

Physical and occupational therapy services are covered for up to 90 consecutive days per injury or illness beginning with the first visit. These services are covered only when provided to restore function lost or impaired as the result of an accidental injury or sickness.

For these services to be covered, *Tufts Health Plan* must determine that the *Member's* condition is subject to significant improvement as a direct result of these therapies.

Oral health services (in some cases must be approved by an *Authorized Reviewer*)

Oral Surgery for Dental Treatment

Benefits are provided only for the following procedures when the *Member* has a serious medical condition that makes it essential that he or she be admitted to a general hospital as an *Inpatient* or to a *Day Surgery* unit or ambulatory surgical facility as an *Outpatient* in order for the dental care to be performed safely:

1. extraction of seven or more permanent, sound natural teeth;
2. gingivectomies (including osseous surgery) of two or more gum quadrants;
3. excision of radicular cysts involving the roots of three or more teeth; and
4. removal of one or more bone impacted teeth.

Serious medical conditions include, but are not limited to, hemophilia and heart disease.

Emergency **Care**

Benefits are provided for treatment rendered by a dentist within 72 hours of an accidental injury to the mouth and sound natural teeth. This treatment is limited to initial first aid (trauma care), reduction of swelling, pain relief, covered non-dental surgery and non-dental diagnostic x-rays.

Notes:

- *Emergency* Care qualifies as a *Covered Service* only if the injury to the mouth is caused by a source external to the mouth;
- *Covered Services* do not include any repair or restoration of teeth.

Oral surgical procedures for non-dental medical treatment

Benefits are provided for oral surgical procedures for non-dental medical treatment such as the reduction of a dislocated or fractured jaw or facial bone, and removal or excision of benign or malignant tumors, are covered to the same extent as other covered surgical procedures.

Day Surgery

- *Outpatient* surgery done under anesthesia in an operating room of a facility licensed to perform surgery.
- You must be expected to be discharged the same day and be shown on the facility's census as an *Outpatient*.

***Inpatient* care**

Acute hospital services

- semi-private room (private room when *Medically Necessary*);
- physician's services while hospitalized;
- surgery;
- anesthesia;
- nursing care;
- intensive care/coronary care;
- diagnostic tests, X-ray and lab services;
- radiation therapy;
- dialysis;
- physical, occupational, speech, and respiratory therapies;
- *Durable Medical Equipment* and appliances; and
- drugs.

Bone Marrow Transplants for Breast Cancer and Human organ transplants

Authorized Reviewer approval is required regardless of whether the procedure is provided by a *Tufts HP Provider* or a non-*Tufts HP Provider*.

- Bone marrow transplants for *Members* diagnosed with breast cancer that has progressed to metastatic disease who meet the criteria established by the Massachusetts Department of Public Health.

- Human organ transplants provided to *Members*. These services must be provided at a *Tufts Health Plan* designated transplant facility. The *Plan* pays for charges incurred by the donor in donating the organ to the *Member*, but only to the extent that charges are not covered by any other health insurer. This includes:

  - evaluation and preparation of the donor, and
  - surgery and recovery services when those services relate directly to donating the organ to the *Member*.

Notes:

- The *Plan* **covers** a *Member's* human leukocyte antigen (HLA) testing. See page 38 in "*Outpatient* care" for more information.
- The *Plan* **does not cover** the following services related to bone marrow and human organ transplants:
  - transportation costs incurred in transporting the donated organ;
  - donor charges of *Members* who donate organs to non-*Members*; and
  - search costs for matching or for laboratory testing:
    - to identify a donor for a recipient who is a *Member*, or
    - for a *Member* who volunteers to be considered as a potential organ donor, whether or not the recipient is a *Member*.
- Prior approval by an *Authorized Reviewer* is required at both the In-Network and Out-of-Network Levels of Benefits. See "Important Notes" on page 34 for more information about when you are responsible for obtaining this approval.

Maternity Care

- hospital and delivery services;
- a newborn hearing screening test; and
- well newborn *Child* care in hospital.

Includes *Inpatient* care in hospital for mother and newborn *Child* for at least 48 hours following a vaginal delivery and 96 hours following a caesarean delivery.

Notes:

- *Covered Services* will include one home visit by a registered nurse, physician, or certified nurse midwife; and additional home visits, when *Medically Necessary* and provided by a licensed health care *Provider*. *Covered Services* will include, but not be limited to, parent education, assistance, and training in breast and bottle feeding, and the performance of any necessary and appropriate clinical tests.
- These *Covered Services* will be available to a mother and her newborn *Child* regardless of whether or not there is an early discharge (hospital discharge less than 48 hours following a vaginal delivery or 96 hours following a caesarian delivery).

For information about preregistration of newborn *Children*, see Part 3 (pages 27-29).

Patient care services provided as part of a qualified clinical trial

As required by Massachusetts law, patient care services provided as part of a qualified clinical trial for the treatment of cancer are covered to the same extent as those *Inpatient* services would be covered if the *Member* did not receive care in a qualified clinical trial.

Reconstructive surgery and procedures
(must be approved by an *Authorized Reviewer*)

- services required to repair or restore a bodily function that is impaired as a result of a congenital defect, birth abnormality, traumatic injury, or covered surgical procedure; and
- the following services in connection with mastectomy:
  - reconstruction of the breast affected by the mastectomy;
  - surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - prostheses* and treatment of physical complications of all stages of mastectomy.

    **Prosthetic Devices* are covered as described under "Medical Appliances and Equipment " on page 45.

Removal of breast implants is covered when:

- there is a medical complication related to an implant; or
- there is documented evidence of auto-immune disease.

Notes:

- Cosmetic Surgery is not covered.
- This prior approval by an *Authorized Reviewer* is required at both the In-Network and Out-of-Network Levels of Benefits. See “Important Notes” on page 34 for more information about when you are responsible for obtaining this approval.

Other Health Services

Ambulance services

- Ground and helicopter ambulance transportation for *Emergency* care.
- Airplane ambulance services (e.g., Medflight) when approved by an *Authorized Reviewer*.
- Non-emergency, *Medically Necessary* ambulance transportation between covered facilities.
- Non-emergency ambulance transportation for *Medically Necessary* care when the medical condition of the *Member* prevents safe transportation by any other means. Prior approval by an *Authorized Reviewer* is required.

Extended Care

In an extended care facility (skilled nursing facility, rehabilitation hospital, or chronic hospital) for:

- skilled nursing services;
- chronic disease services; or
- rehabilitative services.

If you no longer need acute care hospital services but cannot be transferred to an extended care facility because no bed is available, *Tufts Health Plan* may arrange for the hospital you are in to provide you extended care services in the hospital.

Note: Covered facility and physician services for Extended Care provided in a skilled nursing facility are limited to a total of $10,000 per *Member* in a calendar year (In-Network and Out-of-Network Levels combined).

Other Health Services – continued

Home health care
(must be approved by an *Authorized Reviewer*)

Coverage is provided for the following services for *Members* who are homebound*:

Home health care services provided by an accredited home health agency under a physician's written order, including:

- home visits by a *Tufts HP* physician;
- inhalation therapy;
- infusion therapy;
- total parenteral nutritional therapy;
- skilled intermittent nursing care and physical therapy; and
- the following services, if determined to be a *Medically Necessary* component of skilled intermittent nursing or physical therapy:
  - speech therapy,
  - occupational therapy,
  - medical social work,
  - nutritional consultation,
  - the use of *Durable Medical Equipment*, and
  - the services of a part-time home health aide.

*To be considered homebound, you do not have to be bedridden. However, your condition should be such that there exists a usual inability to leave the home and, consequently, leaving the home would require a considerable and taxing effort. If you leave the home, you may be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or to receive medical treatment.

Notes:

- Home health care services for physical and occupational therapies following an injury or illness are only covered to the extent that those services are provided to restore function lost or impaired, as described under "Short term physical and occupational services" on page 40. However, those home health care services are not subject to the 90-day limit listed under "Short term physical and occupational services".
- The *Plan* also covers *Durable Medical Equipment* in connection with home health care services. For coverage information, see "Medical Appliances and Equipment" on page 45.

Hospice care services

The *Plan* will cover the following services for *Members* (having a life expectancy of 6 months or less):

- physician services;
- nursing care provided by or supervised by a registered professional nurse;
- social work services;
- volunteer services; and
- counseling services (including bereavement counseling services for the *Member's* family or a primary care person for up to one year following the *Member's* death).

"Hospice care services" are defined as a coordinated licensed program of services provided, during the life of the *Member*, to a terminally ill *Member*. Such services can be provided:

- in a home setting;
- on an *Outpatient* basis; and

- on a short-term *Inpatient* basis, for the control of pain and management of acute and severe clinical problems which cannot, for medical reasons, be managed in a home setting.

Other Health Services – continued

Injectable medications

Coverage is provided for injectable medications as part of *Outpatient Covered Services*, unless covered under the Prescription Drug Benefit in this Part 5 (see pages 48-52).

Note: Prior authorization and dispensing limits may apply.

Medical Appliances and Equipment

- *Durable Medical Equipment*

  Examples of covered items:

  - Prosthetic Devices (such as artificial legs, arms, eyes, or breasts);
  - orthotic devices (such as knee and back braces); and
  - blood glucose monitors, including voice synthesizers for blood glucose monitors for use by the legally blind;
  - oral appliances for the treatment of sleep apnea;
  - equipment such as hospital beds, wheelchairs, crutches, walkers, and devices that extract oxygen from the air (for example, oxygen concentrators).

  Tufts Health Plan will decide whether to purchase or rent the equipment for you. This equipment must be purchased or rented from a *Durable Medical Equipment Provider* that has an agreement with *Tufts Health Plan* to provide such equipment.

  Examples of excluded items:

  - air conditioners or air purifiers;
  - articles of special clothing, except for gradient pressure support aids for lymphedema or venous disease and clothing necessary to wear a covered device (e.g., mastectomy bras and stump socks);
  - bed pans;
  - comfort or convenience devices;
  - dehumidifiers;
  - dentures;
  - elevators;
  - exercise equipment;
  - foot orthotics and arch supports, except for therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease;
  - heating pads;
  - hot water bottles; or
  - self-monitoring devices, except for certain devices that *Tufts Health Plan* determines would provide a *Member* with the ability to detect or prevent the onset of a sudden life-threatening condition.

  Note: Certain *Durable Medical Equipment* may require *Authorized Reviewer* approval at both the In-Network and Out-of-Network Levels of Benefits. See "Important Notes" on page 34 for more information about when you are responsible for obtaining this approval.). Contact the Member Services Department with coverage questions.

- Other Medical Appliances and Equipment

  - The first pair of eyeglass lenses (eyeglass frames are not covered) or contact lenses following cataract surgery.
  - Contact lenses, including the fitting of the lenses, when required to treat keratoconus.
  - Hearing aids, including the fitting of the hearing aid, are covered when prescribed by a physician and obtained from a hearing aid supplier.

    When there is a pathological change in the *Member's* hearing or the hearing aid is lost, benefits for a replacement hearing aid are also covered.

    Note: This *Plan* will only cover one hearing aid per *Member* every two years. Covered in full up to the 1st $500. Then, the *Plan* pays 80% of the next $1,500 (In-Network and Out-of-Network Levels combined); the *Member* is responsible for paying 20% of the $1,500 (plus any balance).

Other Health Services -- continued

Personal Emergency Response Systems (PERS)

Covered Services are provided only for installation and rental charges for a hospital-based Personal Emergency Response System when:

- the system is used as an alternative to reduce or divert *Inpatient* admissions;
- the patient is homebound and medically at risk, as determined by *Tufts Health Plan*; and
- the patient is alone for at least four (4) hours each day, five (5) days a week and is functionally impaired.

Covered Services do not include the purchase of a Personal Emergency Response System.

Note: Covered PERS benefits are limited to a total of $50 per *Member* for installation charges and $40 per *Member* each month for rental of the system.

Private Duty Nursing

- *Inpatient* private duty nursing services qualify as *Covered Services* when:
  - the frequency and complexity of the skilled nursing care is such that the health care facility's regular nursing staff could not perform the services;
  - the *Member* is a Hospital *Inpatient* for the treatment of a medical condition; and
  - the services are *Medically Necessary*, as determined by *Tufts Health Plan*.

- Private duty nursing services provided in the *Member's* home qualify as *Covered Services* when:
  - the frequency and complexity of the skilled nursing care is such that the administration of treatment and the evaluation of the patient's response to the treatment require the skills of a registered nurse; and
  - the services are *Medically Necessary*, as determined by *Tufts Health Plan*.

Note: Any combination of Covered private duty nursing services (whether as an *Inpatient* or at home) are limited to a total of $8,000 per *Member* in a calendar year (In-Network and Out-of-Network Levels combined).

Scalp hair prostheses or wigs for cancer or leukemia patients

The *Plan* covers scalp hair prostheses or wigs worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia.

Note: *Covered Services* for these prostheses and wigs are limited to a total of $350 per *Member* in a calendar year (In-Network and Out-of-Network Levels combined).

Special medical formulas

Included in this benefit are the following: special medical formulas; nonprescription enteral formulas; and low protein foods, when prescribed by a physician for the treatments described below:

Low protein foods:

When given to treat inherited diseases of amino acids and organic acids.

Note: Covered up to a maximum benefit of $2,500 per calendar year (In-Network and Out-of-Network Levels combined).

Other Health Services -- continued

Nonprescription enteral formulas (prior approval by an *Authorized Reviewer* may be required)

- For home use for treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.
- When *Medically Necessary*: infant formula for milk or soy protein intolerance; formula for premature infants; and supplemental formulas for growth failure.

Note: Services may require prior approval by an *Authorized Reviewer* at both the In-Network and Out-of-Network Levels of Benefits. See "Important Notes" on page 34 for more information about when you are responsible for obtaining this approval.

Special medical formulas (prior approval by an *Authorized Reviewer* may be required)

- For the treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, and methylmaloric acidemia; or
- when *Medically Necessary*, to protect the unborn fetuses of women with PKU.

Note: Services may require prior approval by an *Authorized Reviewer* at both the In-Network and Out-of-Network Levels of Benefits. See "Important Notes" on page 34 for more information about when you are responsible for obtaining this approval.

Spinal manipulation

Spinal manipulation, when provided by a chiropractor.

Note: Benefits for Covered spinal manipulation services are limited to a total of 20 visits per *Member* in a calendar year (In-Network and Out-of-Network Levels combined).

Prescription Drug Benefit

Introduction

This section describes the prescription drug benefit. The following topics are included in this section to explain your prescription drug coverage:

- How Prescription Drugs Are Covered
- Prescription Drug Coverage Table
- What is Covered
- What is Not Covered
- Tufts HP Pharmacy Management Programs
- Filling Your Prescription

How Prescription Drugs Are Covered

Prescription drugs will be considered *Covered Services* only if they comply with the *Tufts Health Plan* Pharmacy Management Programs section described below and are:

- listed below under *What is Covered*;
- provided to treat an injury, illness, or pregnancy; and
- *Medically Necessary*.

For a current list of covered drugs, please go to *Tufts Health Plan's* Web site at **www.tuftshealthplan.com**, or call the Member Services Department. For a list of non-covered drugs, please see Part 10 (pages 73-74).

PRESCRIPTION DRUG COVERAGE TABLE	
Description	**Coverage**
DRUGS OBTAINED AT A RETAIL PHARMACY: Covered prescription drugs (including both acute and maintenance drugs), when you obtain them directly from a Tufts HP designated retail pharmacy.	**Tier-1 drugs (many generic drugs are on Tier-1):** $10 *Copayment* for up to a 30-day supply $20 *Copayment* for a 31-60 day supply $30 *Copayment* for a 61-90 day supply **Tier-2 drugs:** $20 *Copayment* for up to a 30-day supply $40 *Copayment* for a 31-60 day supply $60 *Copayment* for a 61-90 day supply **Tier-3 drugs:** $35 *Copayment* for up to a 30-day supply $70 *Copayment* for a 31-60 day supply $105 *Copayment* for a 61-90 day supply
DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY: Most maintenance medications, when mailed to you through the Tufts HP designated mail services pharmacy.	**Tier-1 drugs (many generic drugs are on Tier-1):** $20 *Copayment* for up to a 90-day supply **Tier-2 drugs:** $40 *Copayment* for up to a 90-day supply **Tier-3 drugs:** $70 *Copayment* for up to a 90-day supply

Note: If you fill your prescription in a state that allows you to request a brand-name drug even though your physician authorizes the generic equivalent, you will pay the applicable Tier *Copayment plus* the difference in cost between the brand-name drug and the generic drug.

Prescription Drug Benefit, continued

What is Covered

The Navigator Plan covers the following under this Prescription Drug Benefit:

- Prescribed drugs (including hormone replacement therapy for peri and post-menopausal women) that by law require a prescription and are not listed under "What is Not Covered" (see "Important Notes" later in this Prescription Drug Benefit).
- Insulin, insulin pens, insulin needles and syringes; lancets; blood glucose, urine glucose, and ketone monitoring strips; and oral diabetes medications that influence blood sugar levels.
- Retin-A ® and similar prescription drug products for individuals through the age of 25.
- Oral contraceptives, diaphragms, and Depo-Provera*.

  *Note: This Prescription Drug Benefit only describes coverage for oral contraceptives, diaphragms, and Depo-Provera. See "Family Planning Procedures, Services, and Contraceptives" on page 36 for information about other contraceptive drugs and devices that qualify as *Covered Services*. Also note that, in certain circumstances, Depo-Provera may qualify as a *Covered Service* under the "Family Planning Procedures, Services, and Contraceptives" benefit.
- Fluoride for *Children*.
- Injectables and biological serum, except as covered under "Injectable medications" on page 45.
- Prefilled sodium chloride for inhalation (both prescription and over-the-counter).
- Off-label use of FDA-approved prescription drugs used in the treatment of cancer or HIV/AIDS which have not been approved by the FDA for that indication, provided, however, that such a drug is recognized for such treatment:
  - in one of the standard reference compendia;
  - in the medical literature; or
  - by the Commissioner of Insurance.
- Compounded medications, if at least one active ingredient requires a prescription by law.

Note: Certain prescription drug products may be subject to one of the ***Tufts Health Plan* Pharmacy Management Programs** described below.

Prescription Drug Benefit, Continued

What is Not Covered

The Navigator Plan does not cover the following under this Prescription Drug Benefit:

- Prescription and over-the-counter homeopathic medications.
- Drugs that by law do not require a prescription (unless listed as covered in the "What is Covered" section above).
- Drugs that are listed in Part 10 (see pages 73-74).
- Vitamins and dietary supplements (except prescription prenatal vitamins and fluoride for *Children*).
- Topical and oral fluorides for adults.
- Cervical caps, IUDs, Levonorgestrel (Norplant®), Depo-Provera*, (these are covered under your *Outpatient* care benefit earlier in Part 5 – see "Family Planning Procedures, Services, and Contraceptives" on page 36),

  ***Note:** In certain circumstances, Depo-Provera may qualify as a *Covered Service* under this Prescription Drug Benefit.
- Experimental drugs: drugs that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn.
- Non-drug products such as therapeutic or other *Prosthetic Devices*, appliances, supports, or other non-medical products. These may be provided as described earlier in Part 5 (see "Medical Appliances and Equipment" on page 45).
- Immunization agents. These may be provided under "Preventive health care" (see page 39).
- Prescriptions filled at pharmacies other than *Tufts Health Plan* designated pharmacies, except for *Emergency* care.
- Smoking cessation agents.
- Drugs for asymptomatic onchomycosis, except for *Members* with diabetes, vascular compromise, or immune deficiency status.
- Retin-A ® and similar prescription drug products for individuals 26 years of age or older, unless *Medically Necessary*.
- Drugs which are dispensed in an amount or dosage that exceeds *Tufts Health Plan's* established dispensing limitations.
- Compounded medications, if no active ingredients require a prescription by law.
- Prescriptions filled through an internet pharmacy that is not a Verified Internet Pharmacy Practice Site certified by the National Association of Boards of Pharmacy.
- Prescription medications once they become available over-the-counter. In this case, the specific medication is not covered and the entire class of prescription medications may also not be covered. For more information, call Member Services or check our Web site at **www.tuftshealthplan.com**.

Prescription Drug Benefit, Continued

***Tufts Health Plan* Pharmacy Management Programs**

In order to provide safe, clinically appropriate, cost-effective medications under this Prescription Drug Benefit, *Tufts Health Plan* has developed the following Pharmacy Management Programs:

Dispensing Limitations Program:

Tufts Health Plan limits the quantity of selected medications that *Members* can receive in a given time period, for cost, safety and/or clinical reasons.

Prior Authorization Program:

Tufts Health Plan restricts the coverage of certain drug products that have a narrow indication for usage, may have safety concerns and/or are extremely expensive, requiring the prescribing physician to obtain prior approval from *Tufts Health Plan* for such drugs.

Special Designated Pharmacy Program:

Tufts Health Plan has designated special pharmacies to supply a select number of medications including medications used in the treatment of infertility, multiple sclerosis, hemophilia, hepatitis C and growth hormone deficiency. These pharmacies specialize in providing medications used to treat certain conditions, and are staffed with clinicians to provide support services to *Members*. Medications may be added to this program from time to time. Special pharmacies can dispense up to a 30-day supply of medication at one time.

Non-Covered Drugs With Suggested Alternatives:

While *Tufts Health Plan* covers over 4,500 drugs, a small number of drugs (less than 1%) are not covered because there are safe, effective and more affordable alternatives available. These non-covered drugs are listed in Part 10 (see pages 73-74). All of the alternative drug products are approved by the U.S. Food and Drug Administration (FDA) and are widely used and accepted in the medical community to treat the same conditions as the medications that are not covered.

New-To-Market Drug Evaluation Process:

Tufts Health Plan's Pharmacy and Therapeutics Committee reviews new-to-market drug products for safety, clinical effectiveness and cost. *Tufts Health Plan* then makes a coverage determination based on the Pharmacy and Therapeutics Committee's recommendation.

A new drug product will not be covered until this process is completed – usually within 6 months of the drug product's availability.

IMPORTANT NOTES:

- If your physician feels it is *Medically Necessary* for you to take medications that are restricted under any of the ***Tufts Health Plan*** **Pharmacy Management Programs** described above, he or she may submit a request for coverage. *Tufts Health Plan* will approve the request if it meets the guidelines for coverage. For more information, call the Member Services Department.
- The *Tufts Health Plan* Web site has a list of covered drugs with their tiers. *Tufts Health Plan* may change a drug's tier during the year. For example, if a brand drug's patent expires, *Tufts Health Plan* may move the brand drug from Tier-2 to Tier-3 when the generic drug becomes available. Many generic drugs are available on Tier-1.
- If you have questions about your prescription drug benefit, would like to know the tier of a particular drug, or would like to know if your medication is part of a Pharmacy Management Program, check *Tufts Health Plan's* Web site at **www.tuftshealthplan.com**, or call the Member Services Department.

Prescription Drug Benefit, Continued

Filling Your Prescription

Where to Fill Prescriptions:

You can fill your prescriptions at any *Tufts Health Plan* designated pharmacy. *Tufts Health Plan* designated pharmacies include:

- for the majority of prescriptions, many of the pharmacies in Massachusetts and additional pharmacies nationwide; and
- for a select number of drug products, a small number of special designated pharmacy providers. (For more information about *Tufts Health Plan's* special designated pharmacy program, see ***Tufts Health Plan* Pharmacy Management Programs** earlier in this Prescription Drug Benefit section.) If you have questions about where to fill your prescription, call the Member Services Department.

How to Fill Prescriptions:

- When you fill a prescription, provide your member ID to any *Tufts Health Plan* designated pharmacy and pay your *Copayment*.
- If the cost of your prescription is less than your *Copayment*, then you are only responsible for the actual cost of the prescription.
- If you have any problems using this benefit at a *Tufts Health Plan* designated pharmacy, call the Member Services Department.

- Important: Your prescription drug benefit will only be honored at a *Tufts Health Plan* designated pharmacy. In cases of *Emergency*, please call the Member Services Department at 1-800-870-9488 for instructions about submitting your prescription drug claims for reimbursement.

Filling Prescriptions for Maintenance Medications:

If you are required to take a *maintenance* medication, *Tufts HP* offers you two choices for filling your prescription:

- you may obtain your maintenance medication directly from a *Tufts HP* designated retail pharmacy; or
- you may have most maintenance medications* mailed to you through a *Tufts HP* designated mail services pharmacy.

*The following may not be available to you through a *Tufts HP* designated mail services pharmacy:

- medications for short term medical conditions;
- certain controlled substances and other prescribed drugs that may be subject to exclusions or restrictions;
- medications that are part of *Tufts HP's* Dispensing Limitations program; or
- medications that are part of *Tufts HP's* Special Designated Pharmacy program.

NOTE: Your *Copayments* for covered prescription drugs are shown in the **Prescription Drug Coverage Table** earlier in this section.

Exclusions from Benefits

The *Plan* or Navigator does not cover the following services, supplies, or medications:

- A service, supply or medication that is not *Medically Necessary*, as determined by *Tufts Health Plan*.
- A service, supply or medication that is not a *Covered Service*.
- A service, supply or medication that is not essential to treat an injury, illness, or pregnancy, except for preventive care services.
- A service, supply, or medication if there is a less intensive level of service, supply, or medication or more cost-effective alternative which can be safely and effectively provided, or if the service, supply, or medication can be safely and effectively provided in a less intensive setting.
- A service, supply, or medication that is primarily for personal comfort or convenience.
- *Custodial Care*.
- Services related to non-*covered services*.
- A drug, device, medical treatment or procedure (collectively "treatment") that is *Experimental or Investigative*.

  This exclusion does not apply to:
  - bone marrow transplants for breast cancer;
  - patient care services provided as part of a qualified clinical trial (for the treatment of cancer); or
  - Off-label uses of prescription drugs for the treatment of cancer or HIV/AIDS

  which meet the requirements of Massachusetts law.

  If the treatment is *Experimental or Investigative*, the Navigator Plan will not pay for any related treatments that are provided to the *Member* for the purpose of furnishing the *Experimental or Investigative* treatment.
- Drugs, medicines, materials or supplies for use outside the hospital or any other facility, except as described earlier in this Part 5. Medications and other products which can be purchased over-the-counter except those listed as covered earlier in Part 5.
- Services provided by a relative (by blood or marriage) or friend unless the relative or friend is a *Tufts HP Provider*. If the *Member* is a *Tufts HP Provider*, the *Member* cannot provide or authorize services for himself or herself or a member of his or her immediate family (by blood or marriage).
- Services, supplies, or medications required by a third party which are not otherwise *Medically Necessary*. Examples of a third party are an employer, an insurance company, a school or a court.
- Services for which the *Member* is not legally obligated to pay or services for which no charge would be made if the *Member* had no health plan.
- Care for conditions for which benefits are available under workers' compensation or other government programs other than Medicaid.
- Care for conditions that state or local law requires to be treated in a public facility.

Exclusions from Benefits, Continued

- Any additional fee a *Provider* may charge as a condition of access or any amenities that access fee is represented to cover. Refer to the *Directory of Health Care Providers* to determine if your *Provider* charges such a fee.
- Charges incurred when the *Member*, for his or her convenience, chooses to remain an *Inpatient* beyond the discharge hour.
- Facility charges or related services if the procedure being performed is not a *Covered Service*.
- Dental care and treatment, except as provided under "Oral Health Services" on page 40. Examples of excluded services include: preventive dental care; periodontal treatment; endodontics; alteration of teeth; care related to deciduous (baby) teeth; restorative services (including, but not limited to, crowns, fillings, root canals), and bondings; splints and oral appliances (except for sleep apnea, as described in "Medical Appliances and Equipment" on page 45), including those for TMJ disorders; orthodontics; dentures; dental supplies.
- Surgical removal or extraction of teeth, except as provided under "Oral health services" on page 40.
- Cosmetic (meaning to change or improve appearance) surgery, procedures, supplies, medications or appliances, except as provided under "Reconstructive surgery and procedures" on page 42.
- Rhinoplasty, except as provided under "Reconstructive surgery and procedures" on page 42; liposuction; and brachioplasty.
- Treatment of spider veins; removal or destruction of skin tags.
- Hair removal, except when *Medically Necessary* to treat an underlying skin condition.
- Costs associated with home births.
- Infertility services for *Members* who do not meet the definition of Infertility as described in the "*Outpatient* Care" section on page 37; experimental infertility procedures; the costs of surrogacy; reversal of voluntary sterilization; long-term (longer than 90 days unless the *Member* is in active infertility treatment) sperm or embryo cryopreservation not associated with active infertility treatment; and infertility services which are necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization; donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner; costs associated with donor recruitment and compensation.
- Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the ART service has been approved by an *Authorized Reviewer* and the *Member* is the sole recipient of the donor's eggs.
- Preimplantation genetic testing and related procedures performed on gametes or embryos.
- Treatments, medications, procedures, services and supplies related to: medical or surgical procedures for sexual reassignment; reversal of voluntary sterilization; or over-the-counter contraceptive agents.
- Human organ transplants, except as described on page 41. Expenses for transportation and lodging in connection with human organ transplants are not covered.
- Services provided to a non-*Member*, except as described earlier in Part 5:
  - for organ donor charges under "Human organ transplants" (see page 41);
  - for bereavement counseling services under "Hospice care services" (see page 44);
  - the costs of procurement and processing of donor sperm, eggs, or embryos under "Infertility services" (to the extent such costs are not covered by the donor's health coverage, if any).
- Acupuncture; biofeedback, except for the treatment of urinary incontinence; hypnotherapy; psychoanalysis; TENS units or other neuromuscular stimulators and related supplies; electrolysis; chiropractic services, except as described in " Spinal manipulation" on page 47; *Inpatient* and *Outpatient* weight-loss programs and clinics; relaxation therapies; massage therapies; services by a personal trainer; cognitive rehabilitation programs; cognitive retraining programs. Also excluded are diagnostic services related to any of these procedures or programs.

Exclusions from Benefits, Continued

- Blood, blood donor fees, blood storage fees, or blood substitutes; blood products except for: factor products (monoclonal and recombinant) for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency), and von Willebrand disease, and intravenous immunoglobulin (Gamimune, Gammagard SD, Gammar-IV, Iveegam, Sandoglobulin, Venoglobulin-I/S, Cytogram, Polygam) for treatment of severe immune disorders, certain neurologic conditions, infectious conditions and bleeding disorders.

- Devices and procedures intended to reduce snoring including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.

- Examinations, evaluations or services for educational or developmental purposes, including physical therapy, speech therapy, and occupational therapy, except as provided earlier in Part 5. Vocational rehabilitation services and vocational retraining. Also services to treat learning disabilities, behavioral problems, and developmental delays and services to treat speech, hearing and language disorders in a school-based setting.

- Eyeglasses, lenses or frames; or refractive eye surgery (including radial keratotomy) for conditions which can be corrected by means other than surgery. Except as described in “Medical Appliances and Equipment” on page 45, the Navigator Plan will not pay for eyeglasses, contact lenses or contact lens fittings.

- Hearing aids or hearing aid fittings, except as described under "Medical Appliances and Equipment" on page 45.

- Routine foot care, such as: trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace; foot orthotics or fittings; or casting and other services related to foot orthotics or other support devices for the feet.

  Note: This exclusion does not apply to therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the *Member's* treating doctor, and the shoes and inserts:

  - are prescribed by a *Provider* who is a podiatrist or other qualified doctor; and
  - are furnished by a *Provider* who is a podiatrist, orthotist, prosthetist, or pedorthist.

- Transportation, including transportation by chair car or taxi, except as described in "Ambulance services" on page 43; lodging related to receiving any medical service.

Part 6 - Continuation of Coverage

Overview

Introduction
This section contains information about federal continuation coverage, continuation coverage after the *Subscriber* dies, and Nongroup Coverage.

GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

You are receiving this notice because you are covered under the *Group Insurance Commission's* (*GIC's*) health benefits program. This notice contains important information about your right to continue group health coverage at COBRA group rates if your group coverage otherwise would end due to certain life events. Please read it carefully.

WHAT IS COBRA COVERAGE? COBRA is a federal law under which certain former employees, retirees, *Spouses*, former *Spouses* and *Dependent Children* have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the *GIC's* plan to similarly situated employees or *Dependents*. The *GIC* administers COBRA coverage.

This notice explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the *GIC's* Public Information Unit at 617/727-2301, ext. 801 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **www.dol.gov/ebsa**.

WHO IS ELIGIBLE FOR COBRA COVERAGE? Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless of whether or not other eligible family *members* elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts covered by the *GIC's* Health benefits program, you have the right to choose COBRA coverage if

- You lose your group health coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the *Spouse* of an employee covered by the *GIC's* health benefits program, you have the right to choose COBRA coverage for yourself if you lose *GIC* health coverage for any of the following reasons (known as "qualifying events"):

- Your *Spouse* dies;
- Your *Spouse's* employment with the Commonwealth ends for any reason other than gross misconduct or his/her hours or employment are reduced; or
- You and your *Spouse* divorce, legally separate, or you or your former *Spouse* remarries.

If you have *Dependent Children* who are covered by the *GIC's* health benefits program, each *Child* has the right to elect COBRA coverage if he or she loses *GIC* health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours or employment are reduced;
- The parents divorce or legally separate; or
- The *Dependent* ceases to be a *Dependent Child* (e.g., is over age 19 and is not a full time student, or ceases to be a full-time student).

HOW LONG DOES COBRA COVERAGE LAST? By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce - occurs during the 18 months of COBRA coverage. **You must notify the *GIC* in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage**. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the *GIC* with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage**.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid ***in full*** when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts no longer provides group health coverage to any of its employees; or
- Any reason for which the *GIC* terminates a non-COBRA enrollee's coverage (such as fraud).

The *GIC* will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The *GIC* reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

HOW AND WHEN DO I ELECT COBRA COVERAGE? Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60–day election period, you will lose all rights to COBRA coverage**.

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under Federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when you elect subsequent health plan coverage. If you have COBRA coverage for the maximum period available to you, it provides you the right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. You also have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a *Spouse's* plan) within 30 days after your COBRA coverage ends.

HOW MUCH DOES COBRA COVERAGE COST? Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

HOW AND WHEN DO I PAY FOR COBRA COVERAGE? If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the *GIC* receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period**. After you make your first payment, you will be required to pay for COBRA coverage for each

subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The *GIC* will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement**. Payments should be sent to the *GIC's* address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

CAN I ELECT OTHER HEALTH COVERAGE BESIDES COBRA? Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

YOUR COBRA COVERAGE RESPONSIBILITIES

- **You must inform the *GIC* of any address changes to preserve your COBRA rights;**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above**. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill**. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the *GIC* within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
    - The employee's job terminates or his/her hours are reduced;
    - The employee or former employee dies;
    - The employee divorces or legally separates;
    - The employee or employee's former *Spouse* remarries;
    - A covered *Child* ceases to be a *Dependent*;
    - The Social Security Administration determines that the employee or a covered family member is disabled; or
    - The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the *GIC* of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the *GIC* of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at *Group Insurance Commission*, P. O. Box 8747, Boston, MA 02114-8747.

Death of *Subscriber*

Continuation coverage for surviving *Spouse* and *Dependent Children*

If the event of the death of the *Subscriber*, the surviving *Spouse* and/or eligible *Dependent Children* may continue coverage under this health care program. In order to continue this coverage, the surviving covered *Members* must notify the *GIC*.

Nongroup Coverage

Introduction

This section covers eligibility for and benefits of Nongroup Coverage for *Members*.

Eligibility

If your group coverage ends, you may be eligible to enroll in Nongroup Coverage.

Effective Date of *Nongroup Coverage* and Waiting Period

If *Tufts Health Plan* accepts your application and receives the needed premium, Nongroup coverage starts on your Effective Date, which will be no later than 30 days after *Tufts Health Plan* receives your complete application. Your Effective Date will be on your member ID.

Enrolled *Dependents*' coverage starts when the *Subscriber's* coverage starts, or at a later date if the *Dependent* becomes eligible after the *Subscriber* became eligible for coverage. A *Dependent's* coverage cannot start before the *Subscriber's* coverage starts.

Benefits

- If the *Member* lives **in Massachusetts (except Martha's Vineyard and Nantucket)**, the Nongroup coverage will be a *Tufts Health Plan* HMO product. Please note that Nongroup Coverage may differ from group coverage. Annual Coverage Limitations from the prior group coverage will not continue under Nongroup Coverage.
- If the *Member* either **(1) lives in Martha's Vineyard or Nantucket in Massachusetts or (2) lives outside Massachusetts**, he or she is not eligible for Nongroup coverage through *Tufts HP*. That *Member* should contact either the Member Services Department or his or her state insurance department for information about coverage options which may be available where he or she resides.

For more information

Please call the Member Services Department for more information.

Part 7 - Member Satisfaction Process

Member Appeals Process

Tufts Health Plan ("*Tufts HP*") has a Member Satisfaction Process to address your concerns promptly. This process addresses:

- grievances; and
- appeals (internal inquiries, internal appeals, and expedited appeals).

GRIEVANCES

Internal Grievance Process

Matters related to quality of care, as well as administrative concerns related to *Tufts Health Plan's* policies, procedures, or employee behavior, are reviewed as grievances through the Internal Grievance Process.

If you have a grievance or concern that involves quality of medical care, access to care or service received from *Providers*, you can call the Member Services Department at 1-800-870-9488. The Coordinator will document the details of your situation and will forward the information to *Tufts Health Plan's* Appeals and Grievances Department.

You are encouraged to submit your grievance in writing. You can submit a written grievance to:

Tufts Health Plan
Navigator Plan
Attn: Appeals & Grievances Department
P.O. Box 9193
705 Mt. Auburn Street
Watertown, MA 02471-9193

Your letter should include: your complete name and address; your ID number; a detailed description of your concern; and copies of any supporting documentation.

When *Tufts Health Plan* receives your grievance, *Tufts HP* will acknowledge its receipt in writing within five (5) business days, review it and conduct any necessary follow up. The Appeals and Grievances Department will send you a written response to your grievance within thirty (30) calendar days from the date of receipt.

If your concern involves a *Tufts Health Plan* policy or procedure, or employee behavior, it will be reviewed by the related department. You will be notified in writing of the outcome of the inquiry, for instance any follow-up actions taken as a result of the grievance or the rationale for the existing policy or procedure. If your grievance is about the quality of your care, a *Tufts HP* clinical reviewer will evaluate it. You will be notified in writing when the review has been completed and, when allowable by law, the findings of the review will be communicated to you. If your concern requires immediate attention in the interest of your health, there is an expedited review procedure.

APPEALS

Internal Inquiry Process
If you contact the Member Services Department with a question or concern regarding a benefit coverage decision, the Coordinator will try to resolve the issue to your satisfaction. If you are not satisfied, the coordinator will tell you how to appeal the decision.

APPEALS – continued

Appeal Process

Requests for coverage that was denied as specifically excluded in your *Member Handbook* or for coverage that was denied based on medical necessity determinations are reviewed as appeals through *Tufts Health Plan's* Internal Appeals Process. You may file a request yourself or you may designate someone to act on your behalf in writing. You have 180 days from the date you were notified of the denial of benefit coverage or claim payment to file your appeal.

(i) You can submit a verbal appeal of a benefit coverage decision to the Member Services Department, who will forward it to the Appeals and Grievances Department. You can also submit a written appeal to the address listed above under "Grievances". *Tufts HP* encourages you to submit your appeal in writing to accurately reflect your concerns. Your letter should include:

- your complete name and address;
- your ID number;
- a detailed description of your concern; and
- copies of any supporting documentation.

(ii) Within five (5) business days following *Tufts Health Plan's* receipt of your written appeal, a *Tufts Health Plan* Appeals Analyst will send you an acknowledgment letter and, if appropriate, a request for authorization for the release of your medical and treatment information related to your appeal. Within 48 hours of receipt of a verbal appeal, a *Tufts Health Plan* Appeals Analyst will summarize your request for an appeal and send a copy to you. This summary will serve as the acknowledgment of receipt of your appeal and if appropriate, will include a request for authorization for the release of related medical and treatment information.

Once you have signed and returned the authorization for the release of medical and treatment information to *Tufts Health Plan*, an Appeals Analyst will document the date of receipt and coordinate the investigation of your appeal. In the event that you do not sign and return the authorization for the release of medical and treatment information to *Tufts Health Plan* within thirty (30) calendar days of the day you requested a review of your case, *Tufts HP* may, in its discretion, issue a resolution of the appeal without reviewing some or all of your medical records.

(iii) The *Tufts Health Plan* Benefits Committee will review appeals concerning specific exclusions and make determinations. The *Tufts Health Plan* Appeals Committee will make utilization management (medical necessity) decisions. If your appeal involves an adverse determination (medical necessity determination), it will be reviewed by a medical director and/or a practitioner in the same or in a similar specialty that typically manages the medical condition, procedure, or treatment under review. The medical director and/or practitioner will not have previously reviewed your case. You, or your authorized representative, have the right to present information either in person, by conference call, or by other appropriate technology to the Committee reviewing your appeal. If you would like to address the Committee, you should contact the Appeals Analyst who is handling your appeal. If you ask to attend the meeting, *Tufts HP* will notify you of the date and time. You will have access to any medical information and records relevant to your appeal which are in the possession and control of *Tufts HP*. The time limits of this process will be waived or extended by a mutual written agreement between you or your authorized representative and *Tufts HP*.

(iv) The Appeals Analyst will notify you in writing of the Committee's decision within thirty (30) calendar days of the receipt of your appeal. A copy of the decision will be sent to your physician, except in the case of Mental Health Appeals or if you request otherwise. A determination of claim denial will set forth:

- *Tufts Health Plan's* understanding of the request;
- the reason(s) for the denial;
- a specific reference to the contract provisions on which the denial is based; and
- the clinical rationale for the denial.

The determination of claim denial will also direct the *Member* to the Executive Director of the *GIC* for final appeal review and determination. Claim denials based upon the *Plan's* determination that the service is specifically excluded from coverage in the *Member Handbook* are not appealable to the *GIC*.

Tufts Health Plan maintains records of each inquiry made by a *Member* or by that *Member's* designated representative.

Member Satisfaction Process, continued

Expedited Appeals

You may request an expedited appeal in situations when your health or well-being is at risk, or when coverage for your *Inpatient* care has been denied, by calling the Member Services Department. If your request does not meet the guidelines for an expedited appeal, *Tufts HP* will explain your right to use the standard appeals process.

If your request meets the guidelines for an expedited appeal, it will be reviewed by a medical director and/or practitioner in the same or in a similar specialty that typically manages the medical condition, procedure or treatment under review. The medical director and/or practitioner will not have previously reviewed your case.

Tufts HP will notify you by telephone within one business day after receiving the information necessary to conduct your appeal, but no later than 72 hours after *Tufts Health Plan's* receipt of the request.

If You Have Questions

If you have questions or need help submitting a grievance or an appeal, please call the Member Services Department for assistance.

Limitation on Actions

You cannot file a lawsuit against either Navigator or *Tufts Health Plan* for any claim under this health care program more than two (2) years after the Navigator Plan denies the claim unless you do it within two (2) years from the time the cause of action arose.

Subrogation

The *Plan's* right of subrogation
Whether you are an enrolled *Subscriber* or *Dependent*, you may have a legal right to recover some or all of the costs of your health care from someone else; for example:

- a worker's compensation insurer;
- your own or someone else's auto or homeowner's insurer; or
- the person who caused your illness or injury.

In that case, if the *Plan* pays or will pay for the costs of health care services provided to treat your illness or injury, it has the right to recover those costs in your name, with your consent, directly from that person or company. This is called the *Plan's* right of subrogation. This right has priority, except as otherwise provided by law. The *Plan* can recover against the total amount of any recovery, regardless of whether:

- all or part of the recovery is for medical expenses; or
- the recovery is less than the amount needed to reimburse you fully for the illness or injury.

The *Plan's* right of reimbursement
If you use your legal right to recover money by a lawsuit, settlement or otherwise, and you recover money, the *Plan* has the right to be reimbursed by you. In this case, you must repay the *Plan* for the cost of health care services and supplies that it paid or will pay, up to the total amount of your recovery.

Assignment of benefits
You hereby assign to the *Plan* any benefits you may be entitled to receive from a person or company that caused, or is legally responsible to reimburse you for your illness or injury. Your assignment is up to the cost of health care services and supplies, and expenses, that the *Plan* paid or will pay for your illness or injury.

***Member* cooperation**
You agree:

- to notify the *Plan* of any events which may affect the *Plan's* rights of recovery under this section, such as
  - injury resulting from an automobile accident, or
  - job-related injuries that may be covered by workers' compensation;
- to cooperate with Navigator and *Tufts Health Plan* by
  - providing information and help, and
  - signing documents to help the Plan get reimbursed;
- that Navigator and *Tufts Health Plan* may
  - investigate,
  - request and release information which is necessary to carry out the purpose of this section, and
  - do the things Navigator and *Tufts Health Plan* decide are appropriate to protect the *Plan's* rights of recovery.

Subrogation Agent

Tufts Health Plan may contract with a third party to administer subrogation recoveries. In such case, that subcontractor will act as *Tufts Health Plan's* agent.

Coordination of Benefits

Benefits under other plans

You may have benefits under other plans for hospital, medical, dental or other health care expenses.

The Navigator Plan has a coordination of benefits program (COB) that prevents duplication of payment for the same health care services. We will coordinate benefits payable for *Covered Services* with benefits payable by other plans, consistent with state law.

Primary and secondary plans

The *Plan* will coordinate benefits by determining:

- which plan (Navigator or your other plans) has to pay first when you make a claim; and
- which plan (Navigator or your other plans) has to pay second.

These determinations will be made according to applicable state law and Division of Insurance regulations.

Right to receive and release necessary information

When you enroll in the Plan, you must include information on your membership application about other health coverage you have. After you enroll, you must notify *Tufts Health Plan* of new coverage or termination of other coverage. *Tufts Health Plan* may ask for and give out information needed to coordinate benefits.

You agree to provide information about other coverage and cooperate with *Tufts HP's* COB program.

Right to recover overpayment

The *Plan* may recover, from you or any other person or entity, any payments made that are greater than payments it should have made under the COB program. The *Plan* will recover only overpayments actually made.

For more information

For more information about COB, call the Member Services Department.

Use and Disclosure of Medical Information

Use and disclosure of medical information

For information about how *Tufts Health Plan* uses and discloses your medical information, please contact the Member Services Department. Information is also available on the *Tufts Health Plan* Web site at **www.tuftshealthplan.com**.

For information about how the Commission uses and discloses your medical information, please contact your employer.

Additional Plan Provisions

Tufts Health Plan and *Providers*

Tufts Health Plan arranges for health care services. *Tufts Health Plan* does not provide health care services. *Tufts Health Plan* has agreements with *Providers* practicing in their private offices throughout the *Service Area*. These *Providers* are independent. They are not Navigator's or *Tufts Health Plan's* employees, agents or representatives. *Providers* are not authorized to:

- change this *Member Handbook*; or
- assume or create any obligation for either Navigator or *Tufts Health Plan*.

Neither Navigator nor *Tufts Health Plan* is liable for any *Provider's* acts, omissions, representations, or other conduct

Acceptance of the terms of the Agreement

By enrolling in Navigator, *Subscribers* agree, on behalf of themselves and their enrolled *Dependents*, to all the terms and conditions of the Agreement between the *GIC* and *Tufts Health Plan*, including this *Member Handbook*.

Payments for coverage

Navigator is a self-funded plan. This means that the *GIC* is responsible for funding *Covered Services* for *Members* in accordance with the terms of the *Plan*.

Changes to this *Member Handbook*

The *GIC* may change this *Member Handbook*. Changes do not require any *Member's* consent. Notice of changes will be sent to *Subscribers* and will include the effective date of the change. The *Plan* is responsible for notifying you of changes. Changes will apply to all benefits for services received on or after the effective date.

Notice

Notice to *Members*: When *Tufts Health Plan* sends a notice to you, it will be sent to your last address on file with us. It is important for *Members* to keep their address current with the *GIC*.

Notice to *Tufts Health Plan*: *Members* should address all correspondence to:

Tufts Health Plan
Navigator Plan
705 Mt. Auburn Street
P.O. Box 9173
Watertown, MA 02471-9173

No Third Party Rights

The *Plan* grants rights to *Members*. It is not deemed to create rights in any third parties.

When this *Member Handbook* is Issued and Effective

This *Member Handbook* is issued and effective July 1, 2004 and supersedes all previous *Member Handbooks*.

Circumstances beyond *Tufts HP's* reasonable control

Tufts Health Plan shall not be responsible for a failure or delay in arranging for the provision of services in cases of circumstances beyond the reasonable control of *Tufts HP*. Such circumstances include, but are not limited to: major disaster; epidemic; war; riot; and civil insurrection. In such circumstances, *Tufts HP* will make a good faith effort to arrange for the provision of services.

Terms and Definitions

This section defines the terms used in this *Member Handbook*.

Adoptive Child

An unmarried *Child* under age 19 is an Adoptive *Child* as of the date he or she:

- is legally adopted by the *Subscriber*; or
- is placed for adoption with the *Subscriber*. This means that the *Subscriber* has assumed a legal obligation for the total or partial support of a *Child* in anticipation of adoption. If the legal obligation ceases, the *Child* is no longer considered placed for adoption.

Adult Medical and Surgical Services

Services which include the *Inpatient* care and treatment of *Members* age 18 and older for a medical or surgical condition (e.g., gynecological, gastroenterological, cardiological, and orthopedic services). Please note that *Inpatient* obstetric, pregnancy, and maternity care services are excluded from this definition. For more information about those services, see the "*Obstetric Services*" definition on page 70.

Annual Enrollment Period

The period each year when the *Group Insurance Commission* allows eligible persons to apply for and change coverage under Navigator and any other health plans the *GIC* offers.

Authorized Reviewer

Authorized Reviewers review and approve certain services and supplies to *Members*. Authorized Reviewers are:

- *Tufts Health Plan's Chief Medical Officer* (or equivalent); or
- someone he or she designates.

Benefit Year

The 12-month period of time in each calendar year in which *Tufts Health Plan* calculates benefit limits, *Deductibles*, *Out-of-Pocket Maximums*, and *Coinsurance*.

Child (Children)

The *Subscriber's*:

- Child by birth, stepchild, or *Adoptive Child* who is under age 19; or
- *Adoptive Child;* or
- any other Child under age 19 for whom the *Subscriber* or *Spouse* has legal guardianship.

Coinsurance

The percentage of costs you must pay for certain *Covered Services*.

- For services provided by a non- *Tufts HP Provider*, your share is a percentage of the *Reasonable Charge* for those services.
- For services provided by a *Tufts HP Provider*, your share is a percentage of:
  - the applicable *Tufts Health Plan* fee schedule amount for those services; or
  - the *Tufts HP Provider's* actual charges for those services, whichever is less.

Copayment

Fees you pay for certain *Covered Services* provided or authorized by a *Tufts HP Provider*. *Copayments* are paid to the *Provider* when you receive care unless the *Provider* arranges otherwise. *Copayments* are not applied towards any *Deductible*, *Coinsurance*, or *Out-of-Pocket Maximum*.

Cosmetic Services

Services performed solely for the purposes of improving appearance, which appearance is not the result of accidental injury, congenital anomaly or a previous surgical procedure or disease.

Covered Services

The services and supplies for which the *Plan* will pay. They must be:

- described in Part 5 of this *Member Handbook* (see pages 34-52);
- *Medically Necessary*, as determined by *Tufts Health Plan*; and
- in some cases, approved by an *Authorized Reviewer*.

Note: Covered Services do not include any tax, surcharge, assessment or other similar fee imposed under any state or federal law or regulation on any *Provider*, *Member*, service, supply or medication. They do, however, include any surcharges on the plan such as the Massachusetts Uncompensated Care Pool or New York Health Care Reform Act surcharges, or later billed charges under provider network agreements, such as supplemental provider payments or access fee arrangements.

Custodial Care

- care provided primarily to assist in the activities of daily living, such as bathing, dressing, eating, and maintaining personal hygiene and safety;
- care provided primarily for maintaining the *Member's* or anyone else's safety, when no other aspects of treatment require an acute hospital level of care;
- services that could be provided by people without professional skills or training;
- routine maintenance of colostomies, ileostomies, and urinary catheters; or
- adult and pediatric day care.

Note: Custodial Care is not covered by the *Plan*.

Day Surgery

Any surgical procedure(s) in an operating room under anesthesia for which the *Member* is admitted to a facility licensed by the state to perform surgery, and with an expected discharge the same day. For hospital census purposes, the *Member* is an *Outpatient*, and not an *Inpatient*.

Deductible

The amount you pay in each calendar year for *Covered Services* at the *Out-of-Network level of benefits* before any payments are made under this *Member Handbook*.

Dependent

The *Subscriber's Spouse*, former *Spouse*, *Child*, *Student Dependent* or *Handicapped Child*, or *Child* of unmarried Dependent.

Directory of Health Care Providers

A separate booklet which lists:

- *Tufts HP Provider* physicians and their affiliated *Tufts HP Hospital*;
- hospitals in the Tufts Health Plan network (*Tufts HP Hospitals*); and
- certain other *Tufts HP Providers*.

Note: This booklet is updated from time to time to show changes in *Providers* affiliated with *Tufts Health Plan*. For information about the *Providers* listed in the *Directory of Health Care Providers*, please call Member Services or check our web site at **www.tuftshealthplan.com**.

Durable Medical Equipment

Devices or instruments of a durable nature that:

- are *Medically Necessary*;
- are prescribed by a physician;
- are reasonable and necessary to sustain a minimum threshold of independent daily living;
- are made primarily to serve a medical purpose;
- are not useful in the absence of illness or injury;

- can withstand repeated use; and
- can be used in the home.

Effective Date

The date, according to *Tufts Health Plan's* records, when you become a *Member* and are first eligible for *Covered Services*.

Emergency

An illness or medical condition that manifests itself by symptoms of sufficient severity that the absence of prompt medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:

- serious jeopardy to the physical and/or mental health of a *Member* or another person (or with respect to a pregnant *Member*, the *Member's* or her unborn child's physical and/or mental health); or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part; or
- with respect to a pregnant woman who is having contractions, inadequate time to effect a safe transfer to another hospital before delivery, or a threat to the safety of the *Member* or her unborn child in the event of transfer to another hospital before delivery.

Some examples of illnesses or medical conditions requiring Emergency care are severe pain, a broken leg, loss of consciousness, vomiting blood, chest pain, difficulty breathing, or any medical condition that is quickly getting much worse.

Experimental or Investigative

A service, supply, treatment, procedure, device, or medication (collectively "treatment") is Experimental or Investigative if any of the following is true:

- the drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished or to be furnished; or
- the treatment, or the "informed consent" form used with the treatment, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or federal law requires such review or approval; or
- reliable evidence shows that the treatment is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental, study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis; or
- reliable evidence shows that prevailing opinion among experts regarding the treatment is that more studies or clinical trials are necessary to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis.

Note: Reliable evidence, as used in this section, shall mean only; published reports and articles in the authoritative peer-reviewed medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment; or the written informed consent form used by the treating facility or by another facility studying substantially the same treatment.

Family Plan

Coverage for a *Subscriber* and his or her *Dependents*.

GIC

See *Group Insurance Commission*.

Group Insurance Commission

The Massachusetts state agency responsible for designing this health care program (including eligibility criteria and benefits) for employees and retirees of the Commonwealth of Massachusetts. Also referred to as "GIC."

Handicapped Child

The *Subscriber's* unmarried *Child* who:

- became permanently, physically or mentally Disabled before age 19;
- is incapable of supporting himself or herself due to disability; and
- was covered under the *Subscriber's Family Plan* immediately before reaching age 19 and who receives approval from the *GIC* to continue coverage under the *Family Plan*.

Individual Plan

Coverage for a *Subscriber* only (no *Dependents*).

Inpatient

A patient who is:

- admitted to a hospital or other facility licensed to provide continuous care; and
- classified as an Inpatient for all or a part of the day on the facility's Inpatient census.

In-Network Level of Benefits

The level of benefits that a *Member* receives for any *Covered Services* when care is provided by a *Tufts HP Provider*.

Medically Necessary

A service or supply that is consistent with generally accepted principles of professional medical practice as determined by whether that service or supply:

- is the most appropriate available supply or level of service for the *Member* in question considering potential benefits and harms to that individual;
- is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
- for services and interventions not in widespread use, as based on scientific evidence.

In determining coverage for *Medically Necessary* Services, *Tufts HP* uses guidelines which are:

- developed with input from practicing physicians in the *Tufts HP Service Area*;
- developed in accordance with the standards adopted by national accreditation organizations;
- updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and
- evidence-based, if practicable.

Medical Supplies and Equipment

Items prescribed by a physician and which are *Medically Necessary* to treat disease and injury.

Member

A person enrolled in the Navigator Plan. Also referred to as "you."

Member Handbook

This document, including any future amendments, which describe the Navigator Plan.

Nongroup Coverage

A separate plan of coverage that may be available to a former *Member*.

Obstetric Services

The *Inpatient* care and treatment for any pregnancy-related condition once a diagnosis of pregnancy has been confirmed. Examples include childbirth (including newborn care while the mother and newborn *Child* are in the hospital), preterm labor, and toxemia.

Outpatient

A patient who receives care other than on an *Inpatient* basis. This includes services provided in:

- a physician's office;
- a *Day Surgery* or ambulatory care unit; and
- an *Emergency* room or outpatient clinic.

Note: You are also an Outpatient when you are in a facility for observation.

Out-of-Network Level of Benefits

The level of benefits that a *Member* receives for *Covered Services* when care is not provided by a *Tufts HP Provider*.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the maximum amount of money paid by a *Member* during a calendar year for *Covered Services* at the *Out-of-Network Level of Benefits.*

An Out-of-Pocket Maximum:

- consists of the *Deductible* and *Coinsurance*; and
- does not include any
  - *Copayments*,
  - Preregistration Penalty, or
  - costs for health care services that are not *Covered Services*.

Pediatric Services

The *Inpatient* care and treatment of *Members* under age 18 for a medical or surgical condition. Please note that *Inpatient* obstetric, pregnancy, and maternity care services are excluded from this definition. For more information about those services, see the "Obstetric Services" definition at the top of this page.

Plan

Navigator by Tufts Health Plan™, the *Group Insurance Commission's* self-funded plan administered by *Tufts Health Plan*, which provides you with the benefits described in this *Member Handbook*.

Plan Administrator

The person(s) or entity designated by the *Plan* as the Plan Administrator or, if not so designated, the *Group Insurance Commission*. *Tufts Health Plan* is not the Plan Administrator.

Prosthetic Devices

Medically Necessary items prescribed by a physician that replace all or part of a bodily organ or limb. Examples include breast prostheses and artificial limbs.

Terms and Definitions, Continued

Provider

A health care professional or facility licensed in accordance with applicable state law including, but not limited to, hospitals, physicians, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners, optometrists, podiatrists, licensed speech-language pathologists, and licensed audiologists.

The Navigator Plan will only cover services of a Provider, if those services are:

- listed as *Covered Services* in Part 5 of this *Member Handbook* (see pages 34-52); and
- within the scope of the Provider's license.

Provider Unit

A Provider Unit is comprised of doctors and other health care *Providers* who practice together in the same community and who often admit patients to the same hospital in order to provide their patients with a full range of care.

Reasonable Charge

The lesser of the

- amount charged; or
- amount that *Tufts Health Plan* determines, based upon the fees most often charged by similar *Providers* for the same service in the geographic area in which it is given, to be the reasonable amount for the service.

Routine Nursery Care

Routine care given to a well newborn *Child* immediately following birth until discharge from the hospital.

Service Area

The geographical area approved by the Massachusetts Commissioner of Insurance within which *Tufts Health Plan* has developed a network of *Providers* to afford *Members* with adequate access to *Covered Services*.

Spouse

The *Subscriber's* legal spouse, according to the law of the state in which you reside.

Student Dependent

The *Subscriber's* unmarried *Child* who is:

- enrolled as a full-time student at an accredited educational institution; and
- at least age 19 but less than age 24. Under certain conditions, *Student Dependents* may continue under the *Subscriber's* coverage at age 24 by paying an additional full cost individual premium (see page 33 for more information).

Subscriber

The person who:

- is an employee of the Commonwealth of Massachusetts, non-Medicare eligible retired employee, or non-Medicare eligible surviving spouse of an employee or retiree;
- enrolls in Navigator and signs the membership application form on behalf of himself or herself and any *Dependents*; and
- in whose name the premium contribution is paid.

Tufts Health Plan or Tufts HP

Tufts Benefit Administrators, Inc., a Massachusetts Corporation d/b/a Tufts Health Plan. Tufts Health Plan enters into arrangements with groups or payors underwriting health benefit plans to make available a network of *Providers* and to provide certain administrative services to the health benefit plans including, but not limited to, processing claims for benefits and performing preregistration. *Tufts HP* is not the *Plan Administrator* and does not insure the Navigator Plan.

Tufts HP Hospital

A hospital which has an agreement with *Tufts Health Plan* to provide certain *Covered Services* to *Members*. Tufts HP Hospitals are independent. They are not owned by *Tufts Health Plan*. Tufts HP Hospitals are not *Tufts Health Plan's* agents or representatives, and their staffs are not *Tufts Health Plan's* employees.

Tufts HP Provider

A *Provider* with whom *Tufts Health Plan* has an agreement to provide *Covered Services* to *Members*. *Providers* are not *Tufts Health Plan's* employees, agents or representatives.

Urgent Care

Care provided when your health is not in serious danger, but you need immediate medical attention for an unforeseen illness or injury. Examples of illnesses or injuries in which urgent care might be needed are a broken or dislocated toe, a cut that needs stitches but is not actively bleeding, or symptoms of a urinary tract infection.

Part 10 – Non-Covered Drugs With Suggested Alternatives

This list of non-covered drugs is effective January 1, 2004 and may change during the year. Drugs may be added to this list for safety reasons, when a new drug comes to market, or if a prescription drug becomes available over-the-counter.

IMPORTANT NOTE: Please see our Web site at **www.tuftshealthplan.com** for the most current list or call the Member Services Department.

Brand Name	Suggested Alternatives and Additional Information
Atacand	Benicar, Cozaar, or Diovan (Tier-3, highest *Copayment*)
Atacand HCT	Diovan HCT or Hyzaar (Tier-3, highest *Copayment*)
Avalide	Benicar, Cozaar, or Diovan (Tier-3, highest *Copayment*)
Avapro	Benicar, Cozaar, or Diovan (Tier-3, highest *Copayment*)
Axid	nizatidine (Tier-1, lowest *Copayment*)
Beconase AQ	Nasacort AQ, Flonase, Nasonex or Rhinocort Aqua (Tier-2, middle *Copayment*)
Bextra	ibuprofen, indomethacin, naproxen, diclofenac sodium, sulindac (Tier-1, lowest *Copayment*); or Vioxx, Celebrex (Prior Authorization required) (Tier-3, highest *Copayment*)
Capoten	captopril (Tier-1, lowest *Copayment*)
Clarinex	loratidine and chlorpheniramine (OTC, not covered); Allegra (Tier-3, highest *Copayment*)
Dynacin	minocycline HCl (Tier-1, lowest *Copayment*)
EC Naprosyn	enteric coated naproxen (Tier-1, lowest *Copayment*)
Flagyl 375mg, Flagyl ER	metronidazole tablets 250 mg, 500 mg (Tier-1, lowest *Copayment*)
Genotropin	Humatrope, Nutropin, Protropin, Saizen (Tier-2, middle *Copayment*)
Klonopin	clonazepam (Tier-1, lowest *Copayment*)
Lidex , Lidex E	fluocinonide and fluocinonide E (Tier-1, lowest *Copayment*)
Lopressor	metoprolol (Tier-1, lowest *Copayment*)
Lupron 1mg/ 0.2mL vial and kit	leuprolide 1mg/0.2 mL vial and kit (Tier-1, lowest *Copayment*) (Prior Authorization required for males age 25 and older)
Mevacor	lovastatin (Tier-1, lowest *Copayment*)
Micardis	Benicar, Diovan and Cozaar (Tier-3, highest *Copayment*)
Micardis HCT	Diovan HCT and Hyzaar (Tier-3, highest *Copayment*)
Minocin	minocycline (Tier-1, lowest *Copayment*)
Monistat Dual-Pak	miconazole or clotrimazole (OTC, not covered), Diflucan 150mg (Tier-2, middle *Copayment*) or Terazol 3/7 (Tier-3, highest *Copayment*)
Monodox	doxycycline monohydrate (Tier-1, lowest *Copayment*)
Naprelan	naproxen sodium extended release (Tier-1, lowest *Copayment*)
Pepcid (except suspension)	famotidine (Tier-1, lowest *Copayment*)
Prevacid	omeprazole (Tier-1, lowest *Copayment*) or AcipHex and Nexium (Tier-3, highest *Copayment*) **Please note**: Prevacid is covered for *Members* age 12 and under (Tier-3, highest *Copayment*).
Prilosec	omeprazole (Tier-1, lowest *Copayment*) or AcipHex and Nexium (Tier-3, highest *Copayment*)

Brand Name	Suggested Alternatives and Additional Information
	Please note: Prilosec is covered for *Members* age 12 years and under (Tier-3, highest *Copayment*).

Non-Covered Drugs with Suggested Alternatives, Continued

Brand Name	Suggested Alternatives and Additional Information
Prinivil	lisinopril (Tier-1, lowest *Copayment*)
Prinzide	lisinopril/hydrochlorothiazide (Tier-1, lowest *Copayment*)
Relenza	amantadine (Tier-1, lowest *Copayment*)
Sporanox (capsules only)	Lamisil tablets (Prior Authorization required) (Tier-3, highest *Copayment*)
Tamiflu	amantadine (Tier-1, lowest *Copayment*)
Teveten	Benicar, Cozaar, or Diovan (Tier-3, highest *Copayment*)
Teveten HCT	Diovan HCT or Hyzaar (Tier-3, highest *Copayment*)
Valium	diazepam (Tier-1, lowest *Copayment*)
Vasotec	enalapril (Tier-1, lowest *Copayment*)
Vicoprofen	hydrocodone with acetaminophen combination products or ibuprofen alone (Tier-1, lowest *Copayment*)
Xanax/Xanax XR	alprazolam (Tier-1, lowest *Copayment*)
Zocor	Lipitor and Pravachol (Tier-2, middle *Copayment*)
Zyrtec	Allegra (Tier-3, highest *Copayment*) **Please note**: Zyrtec liquid and tablets are covered for *Members* age 12 and under (Tier 3, highest *Copayment*)
Zyrtec D	Allegra (Tier-3, highest *Copayment*)

Part 11 – Navigator Plan *Inpatient* Hospital *Copayment* Levels

Under the Navigator Plan, *Copayments* for *Inpatient* hospital stays at *Tufts HP Hospitals* for *Obstetric Services*, *Pediatric Services*, and *Adult Medical and Surgical Services* are grouped into *Inpatient* Hospital *Copayment* Levels, which are based upon the quality and efficiency that the hospital delivers for each of these services. (You can call Member Services for more information about the methods used for grouping the hospitals.)

Tufts HP Hospitals that provide better quality and efficiency are included on *Copayment* Level 1. **You will be charged a $200 *Copayment* for *Obstetric Services*, *Pediatric Services*, or *Adult Medical and Surgical Services* at a hospital included in *Copayment* Level 1** for that service.

Tufts HP Hospitals that provide good quality and efficiency are included on *Copayment* Level 2. **You will be charged a $400 *Copayment* for *Obstetric Services*, *Pediatric Services*, or *Adult Medical and Surgical Services* at a hospital included in *Copayment* Level 2** for that service.

Important Note:

These *Copayment* Levels do not apply to:

- specialized hospitals (including the Massachusetts Eye and Ear Infirmary, the New England Baptist Hospital, or the Dana Farber Cancer Institute);
- *Tufts HP Hospitals* with fewer than 100 admissions per year for *Obstetric Services*, *Pediatric Services*, or *Adult Medical and Surgical Services*; or
- *Tufts HP Hospitals* located outside of Massachusetts.

Your *Copayment* at these hospitals is $400.

There are other services for which the *Inpatient* Hospital *Copayment* Levels do not apply. These include:

- Services for newborn *Children* who stay in the hospital beyond the mother's discharge. **These services are covered in full.**
- The *Copayment* Levels also do not apply for Covered Transplant services for adults and *Children* at our In-Network Centers of Excellence. **A $200 *Copayment* is applied for these services at these facilities.**

The Navigator *Inpatient* Hospital *Copayment* List, which appears on pages 76-78, lists hospitals and the applicable *Copayments* for *Inpatient Obstetric Services*, *Pediatric Services*, or *Adult Medical and Surgical Services*.

Navigator *Inpatient* Hospital *Copayment* List

Eastern Massachusetts

Hospital Name	Obstetrical Care *Copayment*	Pediatric Care *Copayment*	Adult Medical/Surgical Care *Copayment*
Lowell General Hospital	**$200**	**$200**	**$200**
Newton-Wellesley Hospital	**$200**	**$200**	**$200**
South Shore Hospital	**$200**	**$200**	**$200**
Boston Medical Center	$400	**$200**	**$200**
Brockton Hospital	$400	**$200**	**$200**
Cambridge Hospital	$400	**$200**	**$200**
Falmouth Hospital	$400	**$200**	**$200**
Salem Hospital (North Shore Medical Center)	$400	**$200**	**$200**
Winchester Hospital	**$200**	**$200**	$400
Beverly Hospital	$400	$400	**$200**
Cape Cod Hospital	$400	$400	**$200**
Faulkner Hospital	$400**	$400**	**$200**
Melrose Wakefield Hospital (Hallmark Health Systems)	$400	$400**	**$200**
Morton Hospital	**$200**	$400	$400
Addison Gilbert Hopsital	$400**	$400**	$400
Anna Jaques Hospital	$400	$400**	$400
Beth Israel Deaconess Hospital – Needham	$400**	$400**	$400
Beth Israel Deaconess Medical Center	$400	$400**	$400
Brigham and Women's Hospital	$400	$400**	$400
Caritas Carney Hospital	$400**	$400	$400
Caritas Norwood Hospital	$400	$400	$400
Charlton Memorial Hospital	$400	$400**	$400
Children's Hospital	$400**	$400	$400*
Dana-Farber Cancer Institute	$400*	$400*	$400*
Emerson Hospital	$400	$400	$400
Good Samaritan Medical Center	$400	$400**	$400
Holy Family Hospital	$400	$400	$400
Jordan Hospital	$400	$400**	$400
Lahey Clinic Hospital	$400**	$400**	$400
Lawrence General Hospital	$400	$400	$400
Lawrence Memorial Hospital (Hallmark Health Systems)	$400**	$400**	$400
Massachusetts Eye and Ear Infirmary	$400*	$400*	$400*
Massachusetts General Hospital	$400	$400	$400
Merrimack Valley Hospital	$400**	$400**	$400
Metrowest Medical Center-Framingham	$400	$400	$400
Metrowest Medical Center – Leonard Morse	$400**	$400**	$400
Milton Hospital	$400**	$400**	$400
Mount Auburn Hospital	$400	$400**	$400
New England Baptist Hospital	$400*	$400*	$400*
New England Medical Center	$400	$400	$400

*Not grouped in a *Copayment* Level – specialized hospital

**Not grouped in a *Copayment* Level – fewer than 100 admissions for pediatrics or obstetrics

Navigator *Inpatient* Hospital List, Continued

Eastern Massachusetts, continued

Hospital Name	Obstetrical Care *Copayment*	Pediatric Care *Copayment*	Adult Medical/Surgical Care *Copayment*
Quincy Medical Center	$400**	$400**	$400
Saints Memorial Medical Center	$400	$400**	$400
St. Anne's Hospital	$400**	$400	$400
St. Elizabeth's Medical Center	$400	$400**	$400
St. Luke's Hospital	$400	$400	$400
Sturdy Memorial Hospital	$400	$400**	$400
Tobey Hospital	$400	$400**	$400
Union Hospital (North Shore Medical Center)	$400**	$400**	$400

*Not grouped in a *Copayment* Level – specialized hospital

**Not grouped in a *Copayment* Level – fewer than 100 admissions for pediatrics or obstetrics

Central Massachusetts

Hospital Name	Obstetrical Care *Copayment*	Pediatric Care *Copayment*	Adult Medical/Surgical Care *Copayment*
Heywood Hospital	$400	**$200**	**$200**
St. Vincent Hospital	$400	**$200**	**$200**
HealthAlliance Hospitals	**$200**	**$200**	$400
Milford-Whitinsville Hospital	**$200**	$400	$400
Athol Memorial Hospital	$400**	$400**	$400
Clinton Hospital	$400**	$400**	$400
Harrington Hospital	$400	$400	$400
Hubbard Regional Hospital	$400**	$400**	$400
Marlborough Hospital	$400**	$400**	$400
Nashoba Valley Medical Center	$400**	$400**	$400
Umass Memorial Medical Center	$400	$400	$400

*Not grouped in a *Copayment* Level – specialized hospital

**Not grouped in a *Copayment* Level – fewer than 100 admissions for pediatrics or obstetrics

Western Massachusetts

Hospital Name	Obstetrical Care *Copayment*	Pediatric Care *Copayment*	Adult Medical/Surgical Care *Copayment*
Baystate Medical Center	$400	**$200**	**$200**
Franklin Medical Center	**$200**	$400**	$400
Mercy Medical Center	**$200**	$400**	$400
Berkshire Medical Center	$400	$400	$400
Cooley Dickinson Hospital	$400	$400	$400
Fairview Hospital	$400	$400**	$400
Holyoke Hospital	$400	$400**	$400
Mary Lane Hospital	$400	$400**	$400
Noble Hospital	$400**	$400**	$400
North Adams Regional Hospital	$400	$400**	$400
Wing Memorial Hospital	$400**	$400**	$400

*****Not grouped in a *Copayment* Level – specialized hospital

**Not grouped in a *Copayment* Level – fewer than 100 admissions for pediatrics or obstetrics

Navigator *Inpatient* Hospital List, Continued

New Hampshire

Hospital Name	Obstetrical Care *Copayment*	Pediatric Care *Copayment*	Adult Medical/Surgical Care *Copayment*
Catholic Medical Center	$400***	$400***	$400***
Elliot Hospital	$400***	$400***	$400***
Mary Hitchcock Memorial	$400***	$400***	$400***
Parkland Medical Center	$400***	$400***	$400***
Southern N.H. Regional Medical Center	$400***	$400***	$400***
St. Joseph Hospital	$400***	$400***	$400***

***Not grouped in a *Copayment* Level – *Tufts HP Hospital* outside of Massachusetts

Rhode Island

Hospital Name	Obstetrical Care *Copayment*	Pediatric Care *Copayment*	Adult Medical/Surgical Care *Copayment*
Kent County Hospital	$400***	$400***	$400***
Landmark Medical Center	$400***	$400***	$400***
Memorial Hospital of RI	$400***	$400***	$400***
Miriam Hospital	$400***	$400***	$400***
Newport Hospital	$400***	$400***	$400***
Rhode Island Hospital – including Hasbro Children's Hospital	$400***	$400***	$400***
Roger Williams Hospital	$400***	$400***	$400***
St. Joseph's Hospital	$400***	$400***	$400***
Women and Infants Hospital	$400***	$400***	$400***

***Not grouped in a *Copayment* Level – *Tufts HP Hospital* outside of Massachusetts

United Behavioral Health
Member Handbook

Mental Health, Substance Abuse and Enrollee Assistance Programs

Description of Benefits

PART I – HOW TO USE THIS PLAN

A Comprehensive Plan Designed With Your Well-Being In Mind

As a covered person under Navigator, you are automatically enrolled in the mental health and substance abuse benefits program as well as the Enrollee Assistance Program (EAP) administered by United Behavioral Health. These programs offer you easy access to a broad range of services -- from assistance with day-to-day concerns (e.g., legal and financial consultations, workplace-related stress, child- and elder-care referrals) to mental health and substance abuse needs, including assistance in a psychiatric emergency. By offering effective, goal-focused care delivered by a network of highly qualified providers, this program is designed to improve well-being and functioning as quickly as possible.

United Behavioral Health (UBH) is administering the benefits under this program on behalf of the insurer, United HealthCare Insurance Company (UHC).

Let Us Show You the Benefits

The following describes your mental health, substance abuse and EAP benefits under the UBH plan. Please read it carefully before you seek care to ensure that you are receiving maximum benefits. The chart on pages 87-88 provides a brief overview of your benefits; however, it is not a detailed description. A more detailed description of your benefits is found in Part III on pages 89-94. Words in italics in this description are defined in the "Definitions" section in Part II on pages 85-86.

This is the "Description of Benefits" for your mental health, substance abuse and EAP services. While it is a full description of the available benefits under this plan, it is not the "Evidence of Coverage," the legal policy document that UBH submits to the Massachusetts Division of Insurance (DOI). The "Evidence of Coverage" governs the plan and includes state and federal mandated language, required disclosures to the Massachusetts Office of Patient Protection, continuation of coverage provisions as directed by state and federal law, and other required plan disclosures. The full "Evidence of Coverage" is available in electronic form and can be downloaded from the UBH website **www.liveandworkwell.com** (access code: 10910). If you would prefer a paper copy of this document please send a written request to UBH at the address provided on the bottom of page 82, and a copy will be sent to you free of charge.

How to Ensure Maximum Benefits

In order to receive maximum benefits and reduce your out-of-pocket expenses, there are two important steps you need to remember:

Step 1: Call UBH for *precertification* before you seek mental health, substance abuse services or EAP services; and

Step 2: Use a provider or facility from the UBH network.

UBH offers you a comprehensive network of resources and experienced providers from which to obtain mental health, substance abuse and EAP services. All UBH *network providers* have been reviewed by UBH for their ability to provide quality care. If you receive care from a provider or facility that is not part of the UBH network, your benefits will be lower than for network care. These reduced benefits are defined as out-of-network benefits. If you fail to call UBH to *precertify* your care, you may be charged a penalty and your benefits may be reduced. In some cases, if you fail to *precertify* your care, no benefits will be paid. Please refer to Part 3, titled **Benefits Explained**, on page 89, for a full description of your network and out-of-network benefits, as well as special *precertification* requirements for certain out-of-network outpatient services. **Benefits will be denied if your care is considered not to be a *covered service***.

BEFORE YOU USE YOUR BENEFITS

Precertification

Precertification is the first step to obtaining your mental health, substance abuse and EAP benefits. To receive EAP services or before you begin mental health and substance abuse care, call UBH at 1-888-610-9039 (TDD: 1-800-842-9489).

A trained *UBH clinician* will answer your call 24 hours a day, seven days a week, verify your coverage and refer you to a specialized EAP resource or a *network provider*. All *UBH clinicians* are experienced professionals with master's degrees in psychology, social work, or a related field. A *UBH clinician* will immediately be available to assist you with routine matters or an emergency. If you have specific questions about your benefits or claims, call a customer service representative from 9 a.m. to 8 p.m. Eastern Time at 1-888-610-9039 (TDD: 1-800-842-9489).*

Based on your specific needs, the *UBH clinician* will *precertify* visits if you are eligible for coverage at the time of your call, and provide you with the names of several mental health, substance abuse or EAP providers who match your needs (e.g., provider location, gender, or fluency in a second language). UBH maintains an extensive database of information on every provider in the network. A directory of UBH providers can be found on the UBH web site, www.liveandworkwell.com (access code 10910). After *precertification*, you can then call the provider directly to schedule an appointment. **If you need assistance, a *UBH clinician* can help you in scheduling an appointment.** The *UBH clinician* can also provide you with a referral for legal, financial, or dependent care assistance or community resources, depending on your specific needs.

Emergency Care

Emergency care is required when a person needs immediate clinical attention because he or she presents a real and significant risk to him/herself or others. In a life-threatening emergency, you and/or your covered dependents should seek care immediately at the closest emergency facility. You, a family member or your provider must call UBH **within 24 hours** of an emergency admission to notify UBH of the admission. Although a representative may call on your behalf, it is always the covered person's responsibility to ensure that UBH has been notified. If UBH is not notified of the admission, you will not be eligible for maximum benefits or benefits may be denied. UBH staff is available 24 hours a day, seven days a week, to assist you and/or your covered family members.

Urgent Care

There may be times when a condition shows potential for becoming an emergency if not treated immediately. In such urgent situations, a UBH *network provider* will have an appointment to see you within 24 hours of your initial call to UBH. Call 1-888-610-9039 (TDD: 1-800-842-9489) for immediate assistance.

Routine Care

Routine care is for conditions that present no serious risk, and are not in danger of becoming an emergency. For routine care, network providers will have an appointment to see you within three days of your initial call to UBH. Call 1-888-610-9039 (TDD: 1-800-842-9489) for immediate assistance.

Enrollee Assistance Program

Your Enrollee Assistance Program benefit provides access to a range of resources, as well as focused, confidential, short-term counseling to treat problems of daily living (e.g., emotional, marital or family problems, legal disputes, or financial difficulties). The EAP benefit provides counseling and other professional services to you and your family members who are experiencing problems disrupting your personal and professional lives (e.g. international events, community trauma). The EAP can also provide critical incident response, on-site behavioral health consultation and seminars for state agencies.

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* As part of UBH's quality control program, supervisors monitor random calls to UBH's customer services department, but not the clinical department.

Confidentiality

When you use your mental health, substance abuse and EAP benefits under this plan, you are consenting to the release of necessary clinical records to UBH for *case management* and benefit administration purposes. Information from your clinical records will be provided to UBH only to the minimum extent necessary to administer and manage the care provided when you use your EAP, mental health, and substance abuse benefits, and in accordance with state and federal laws. All of your records, correspondence, claims, and conversations with UBH staff are kept **completely confidential** in accordance with federal and state laws. No information may be released to your supervisor, employer, or your family without your written permission, and no one will be notified when you use your EAP, mental health, and substance abuse benefits. UBH staff must comply with a strict confidentiality policy.

Complaints

If you are not satisfied with any aspect of the UBH program, we encourage you to call UBH at 1-888-610-9039 (TDD: 1-800-842-9489) to speak with a customer service representative. The UBH customer service representative resolves most complaints during your initial call. Complaints that require further research are reviewed by representatives of the appropriate departments at UBH, including clinicians, claims representatives, administrators, and other management staff. We will respond to all complaints within three business days. Your comments will help us correct any problems and provide better service to you and your dependents. If the resolution of your complaint is unsatisfactory to you, you have the right to file a formal complaint in writing within 60 days of the date of our telephone call or letter of response. Please specify dates of service and additional contact with UBH and include any information you feel is relevant. Formal complaints will be responded to in writing within 30 days. A formal complaint should be sent to:

United Behavioral Health
Post Office Box 32040
Oakland, CA 94604

Appeals (Grievance)

Your Right to an Internal Appeal (Grievance)

If you disagree with an adverse determination made by United Behavioral Health, you have the right to request an internal appeal review of that determination. In most cases, United Behavioral Health provides one level of internal review. However, in certain cases in which new medical information becomes available after an adverse determination has been made following an internal appeal review, a reconsideration of the adverse determination may be available as outlined in your Evidence of Coverage. After the internal review options have been exhausted, you are then eligible for an External Review Process if you still disagree with the results of the internal review.

An adverse determination is a determination by United Behavioral Health to deny, reduce, modify or terminate benefits for inpatient admission, continued inpatient stay, or any other behavioral health care service, for failure to meet the requirements for a *covered service*.

How to Initiate a First Level Internal Appeal (Grievance) Review

You or your authorized representative may submit an appeal request in writing, by calling the UBH toll-free telephone number or using the fax number, both of which are listed below. You have up to 180 days from the date you received the adverse determination letter to request a first level internal appeal. Written requests should be mailed to:

United Behavioral Health, Appeals Unit
Post Office Box 32040
Oakland, CA 94604-3340
Fax: 415-547-6259
800-888-2998, extension 5182

Appeal requests should include:

- the member's name, Social Security Number, and group policy number;
- the service which is the subject of the adverse determination;
- the reasons why you feel benefit coverage should be approved;
- any available medical information to support your reasons for reversing the adverse determination; and
- a completed authorization release, enclosed, to enable UBH to review your medical information.

You will receive a written acknowledgement of your appeal request within five (5) days of receipt of your written request. Oral requests will be documented and a copy will be forwarded to you within 48 hours of receiving your verbal request.

Internal Appeal (Grievance) Review

An individual who did not participate in the adverse determination will review your appeal. This individual will be an actively practicing health care professional in the same or similar specialty that typically provides the treatment that is the subject of the appeal. United Behavioral Health will notify you or your authorized representative of the decision in writing within 30 days of receipt of your oral or written appeal.

An expedited internal review is available if you are receiving ongoing treatment or services in a hospital at the time of the adverse determination. You have the right to receive coverage of the disputed treatment or service until the completion of the internal appeal process. You or your authorized representative may request an expedited internal appeal by calling the toll-free number listed in the "How to Initiate the First Level Internal Appeal (Grievance)" section above.

A determination will be made and verbal notice provided within 24 hours and a written notification will follow to you and your physician within **one business day**. The written notice will be provided prior to the anticipated discharge. If you are dissatisfied with the outcome of the determination, you have the right to an expedited external review and the right to request continuation of coverage for the services. Please refer to the section below titled "External Review Process" for instructions.

If you have a terminal illness and you disagree with an adverse determination made by United Behavioral Health, you have the right to request an expedited internal appeal review of that determination.

External Review Process

You, your authorized representative or the attending provider may request an external review of an adverse determination that was a result of the internal appeal review. You or your authorized representative may request access to any medical information in the possession or control of the carrier relating to the insured. In order to request an external review, you must:

- Submit your request in writing within 45 days of your receipt of the adverse determination resulting from the internal review.
- Complete the Massachusetts Request for External Appeal form and include the signed authorization of release of medical records
- Submit the form along with $25.00 (twenty-five) to the Office of Patient Protection and include a copy of the written adverse determination notice resulting from the internal review to:

The Commonwealth of Massachusetts
Department of Public Health
Office of Patient Protection
250 Washington Street, 2nd Floor
Boston, MA 02108

You have the right to request an expedited external review. This request must be in writing from a physician, stating that delay in providing or continuing health care services, which are the subject of a final adverse determination, would pose a serious and immediate threat to the health of the insured.

The Office of Patient Protection will screen your request for an appeal within 48 hours of receipt for expedited requests, and five (5) business days of receipt for all other requests. Notification of ineligible requests shall be communicated to the member, the member's authorized representative and United Behavioral Health within 72 hours of receipt for an expedited request; and within 10 business days of receipt for all other requests and shall include the reason for the ineligible determination.

If your request is accepted, United Behavioral Health will forward the member's medical and treatment records and a copy of the evidence of coverage applicable to the member, to the external review agency assigned by the Office of Patient Protection within three (3) business days or within 24 hours for expedited requests.

For non-expedited reviews, the external review agency shall make a decision within 60 business days of receipt of the referral from the Office of Patient Protection. For expedited reviews, the external review agency shall make a decision within five (5) business days of receipt from the Office of Patient Protection. The decision shall be in writing, shall identify the decision, set forth the medical and scientific reasons for the decision and shall be binding. If additional time is needed, the external review agency may extend the time period for an additional 15 business days and shall notify all parties of that extension.

How to Contact the Office of Patient Protection at the Department of Public Health

You may contact the Department of Public Health with any questions at: 1-800-436-7757 or via FAX at 1-617-624-5046. You may also access the Department of Public Health's Web Site for additional copies of the required forms at: **http://www.state.ma.us/dph/opp**

Filing Claims

Network providers and facilities will file your claim for you. You are financially responsible for *deductibles* and *copayments*.

Out-of-network providers are not required to process claims on your behalf; you must submit the claims yourself. You are responsible for all coinsurance and deductibles. Send the out-of-network provider's itemized bill and a completed CMS 1500 claim form, with your name, address, and GIC ID number to:

United Behavioral Health
GIC Claims
Post Office Box 30755
Salt Lake City, UT 84130-0755

The CMS 1500 form is available from your provider. Claims must be received by UBH within 15 months of the date of service for you or a covered dependent. You must be eligible for coverage on the date you received care. All claims are confidential.

Coordination of Benefits

All benefits under this plan are subject to coordination of benefits, which determines whether your mental health or substance abuse care is partially or fully covered by another benefit plan. UBH may request information from you about other health insurance coverage in order to process your claim correctly.

For More Information

UBH customer service staff is available to help you. Call 1-888-610-9039 (TDD: 1-800-842-9489) for assistance Monday through Friday, from 9 a.m. to 8 p.m. Eastern Time.

Part II - Benefit Highlights

Definitions of UBH Terms

Allowed Charges means charges conforming to UBH's negotiated fee maximums or reasonable and customary rates. If the cost of treatment for out-of-network care exceeds the *allowed charges*, the covered person may be responsible for the difference.

In Massachusetts, if you choose to use a provider other than a *network provider*, you are responsible for the *coinsurance* amounts up to the *allowed charges*. Providers of services in Massachusetts are prohibited by law from billing you for amounts in excess of *allowed charges*.

Outside Massachusetts, if you chose to use a provider other than a *network provider,* you are responsible for amounts in excess of the *allowed charge*. Amounts in excess of the *allowed charge* are not applied toward satisfying the *deductible, coinsurance* or *out-of-pocket maximum*.

Appeal (Grievance) means a formal request for UBH to reconsider any adverse determination/denial of coverage, either concurrently or retrospectively, for admissions, continued stays, levels of care, procedures, or services.

Case Management means a system of *continuing review* by a UBH clinical case manager, using objective clinical criteria, to determine if treatment is appropriate and is a *covered service* according to the plan of benefits for a covered diagnostic condition.

Coinsurance means the limit of coverage by the plan to a certain percentage of provider costs and fees, such as 80%. The remaining percentage is paid by the covered person. The provider is responsible for billing the member for the remaining percentage.

Complaint means a verbal or written statement of dissatisfaction arising from a perceived adverse administrative action, decision, or policy by UBH.

Continuing Review/Concurrent Review means an assessment of the care while it is being delivered and the proposed treatment plan for future care, conducted at periodic intervals by a clinical case manager to determine the appropriateness of continued care.

Coordination of Benefits (COB) means a methodology, which determines the order and proportion of insurance payment when a covered person has coverage through more than one insurer. The regulations define which organization has primary responsibility for payment and which organization has secondary responsibility for any remaining charges not covered by the "primary plan."

Copayment means a fixed dollar amount that a covered person must pay out of his or her own pocket.

Covered Services are services and supplies provided for the purpose of preventing, diagnosing or treating a behavioral disorder, psychological injury or substance abuse addiction and which are described in the section titled "What This Plan Pays," and not excluded under the section titled "What's Not Covered - Exclusions."

Cross Accumulation means the sum of applicable expenses paid by a covered person to determine whether a *deductible* or *out-of-pocket maximum* has been reached.

Deductible means the designated amount that a covered person must pay for any charges before insurance coverage applies.

Intermediate Care means care that is more intensive than traditional outpatient treatment but less intensive than 24-hour hospitalization. Some examples are residential treatment, group homes, halfway houses, therapeutic foster care, day or partial hospital programs, or structured outpatient programs.

Network Provider is a provider who participates in the United Behavioral Health network.

Non-Notification Penalty means the amount charged when you fail to *precertify* care. It does not count towards the *out-of-pocket maximum.*

Out-of-Network Provider is a provider who does not participate in the United Behavioral Health network.

Out-of-Pocket Maximum means the maximum amount you will pay in *coinsurance* and *copayments* for your mental health and substance abuse care in one calendar year. When you have met your *out-of-pocket maximum,* all care will be covered at 100% of the *allowed charge* until the end of that calendar year. This maximum does not include the *non-notification penalty*, the out-of-network calendar year *deductible*, the out-of-network inpatient *deductible*, charges for care not deemed to be a *covered service*, and charges in excess of UBH's *allowed charges*.

Precertification (Precertify) is the process of registering for services with UBH prior to seeking EAP, mental health, and substance abuse care. All *precertification* is performed by *UBH clinicians*.

UBH Clinician refers to the staff member who *precertifies* EAP, mental health, and substance abuse services. *UBH clinicians* must have the following qualifications: Master's degree in psychology, social work, or a related field; three or more years of clinical experience; Certified Employee Assistance Professionals (CEAP) certification or eligibility; and a comprehensive understanding of the full range of EAP services for employees and employers, including workplace and personal concerns.

What This Plan Pays

The Plan pays for the following services:

- **Outpatient Care** - Individual or group sessions with a therapist, usually conducted once a week, in the provider's office or facility.
- **Intermediate Care** - Care that is more intensive than traditional outpatient services, but less intensive than 24-hour hospitalization. Some examples are residential treatment, group homes, halfway houses, therapeutic foster care, day/partial hospitals, or structured outpatient programs.
- **In-Home Care** - A licensed mental health professional visits the patient in his or her home.
- **Inpatient Care** - Treatment in a hospital or substance abuse facility.
- **Detoxification** - Medically supervised withdrawal from an addictive chemical substance, which may be done in a substance abuse facility.
- **Drug Testing** - *Precertified* drug testing is covered as an adjunct to substance abuse treatment.

The Plan also covers:

- **Enrollee Assistance Program** - Short-term counseling or other services that focus on problems of daily living, such as marital problems, conflicts at work, legal or financial difficulties, and dependent care needs.
- **www.liveandworkwell.com** - An interactive web site offering a large collection of wellness articles, service databases including a UBH Massachusetts *network provider* directory, tools, financial calculators and expert chats. To enter the site, log on to www.liveandworkwell.com and enter access code 10910.

These services are subject to certain Exclusions, which are found in Part III.

Benefit Chart

The following benefit chart summarizes certain benefits available to you. Be sure to read Part III, which describes your benefits in greater detail and notes some important restrictions. Remember, in order to receive the maximum benefits, you must *precertify* your care with UBH before you begin treatment. For assistance, please call toll-free 24 hours a day, seven days a week: 1-888-610-9039.

Covered Services	**Network**	**Out-of-Network**
Annual Deductible	None	$150 per person (a,b) $300 per family (a)
Annual *Out-of-Pocket Maximum*	$1,000 per person (a) $2,000 per family (a)	$3,000 per person (a) No family maximum
Benefit Maximums	Unlimited	See *Covered Service* Benefit Maximum
Inpatient Care (Benefit levels listed below apply after applicable *deductibles* are met)		
Deductible	$200 per calendar quarter (a)	$150 per admission (applies after annual *deductible* is met) (a)
Mental Health General Hospital Psychiatric Hospital **Substance Abuse (c)** General Hospital Or Substance Abuse Facility	Full coverage	80% of *allowed charges*
All hospital care must be *precertified.* Emergency admissions must be *precertified* within 24 hours to receive maximum benefits. The *non-notification penalty* for failure to *precertify* care is $200. The non-notification penalty does not count toward *out-of-pocket maximums* or *deductibles*.		
Intermediate Care (d) (Intensive outpatient care, partial hospitalization, group home, therapeutic foster care, residential treatment and other acute care alternatives)	Full coverage	80% of *allowed charges* after *deductible* is met
Outpatient Care (d) (e) (f) (g) - Mental Health, Substance Abuse and *Enrollee Assistance Program (EAP)*		
First four visits (Individual and/or Group therapy)	Full coverage	80% of *allowed charges* (e) (f)
Visits 5 to 15 (Individual therapy)	Full coverage after $15 copay per visit	80% of *allowed charges* (e) (f)
Visits 16 and over (individual therapy)	Full coverage after $15 copay per visit	50% of *allowed charges* (e) (g)
EAP *non-notification penalty* reduces benefits to zero; no benefits paid.		

Covered Services	Network	Out-of-Network
Visits 5 to 15 (Group therapy)	Full coverage after $10 copay per visit	80% of allowed charges (e) (f)
Visits 16 and over (Group therapy)	Full coverage after $10 copay per visit	50% of allowed charges (e) (g)
Medication Management (15-30 minute psychiatrist visit.)	Full coverage after $5 copay per visit	80% of allowed charges for outpatient visits 1-15 (e) (f) 50% of allowed charges for outpatient visits 16 and over (e) (g)
In-Home Mental Health Care	Full coverage	80% of allowed charges for outpatient visits 1-15 (e) (f) 50% of allowed charges for outpatient visits 16 and over (e) (g)
Drug Testing (as an adjunct to Substance Abuse treatment)	Full coverage	No coverage
Non-notification penalty reduces benefit to zero: no benefit paid.		
Provider Eligiblity – Provider must be licensed in one of these disciplines	MD Psychiatrist, PhD, PsyD, EdD, MSW, MSN, LICSW, RNMSCS (h)	

(a) Separate from medical deductible and medical out-of-pocket maximum. Network and Out-of-Network out-of-pocket maximums do not cross accumulate.
(b) Cross accumulates with all Out-of-Network mental health and substance abuse benefit levels.
(c) Substance Abuse Rehabilitation Incentive Program: Members are reimbursed for inpatient and outpatient copays if they complete inpatient and post-discharge care.
(d) Treatment that is not precertified receives the Out-of-Network level reimbursement, except as noted in item (g) below.
(e) All Out-of-Network outpatient visits in a given benefit year, including mental health, substance abuse and EAP outpatient visits, medication management visits and in-home mental health care visits, are accumulated to determine the appropriate Out-of-Network level of reimbursement.
(f) No precertification is required for Out-of-Network outpatient visits 1 through 15, per benefit plan year.
(g) Out-of-Network outpatient visits 16 and over, per benefit plan year, are subject to the same precertification requirements as Network benefits in order to be eligible for coverage. If Out-of-Network ouptatient visits 16 and over are not precertified, no benefit will be paid for those services.
(h) Massachusetts independently licensed providers; psychiatrists, licensed clinical social workers, psychiatric nurse clinical specialist and allied mental health professionals.

Please note: the words in italic have special meanings that are given in the Glossary section.

All benefits are paid in accordance with the Allowable Charges. Refer to the Glossary for the definition of Allowable Charges.

Out-of-Network services, except for Out-of-Network outpatient visits 16 and over, are subject to Utilization Review at the time a claim is submitted for payment in order to determine if the services meet the Clinical Necessity criteria for Behavioral Health Services. Out-of-Network outpatient visits 16 and over require precertification in order to be eligible for

coverage.

PART III -- BENEFITS EXPLAINED

Mental Health and Substance Abuse Benefits

Network Services

In order to receive maximum network benefits for EAP, mental health, and substance abuse treatment you must call United Behavioral Health toll-free at 1-888-610-9039 (TDD: 1-800-842-9489) to *precertify* care and obtain a referral to a *network provider*.

Precertified network services are paid at 100% after the appropriate *deductible* and *copayment* (see schedule on page 87). The calendar year *out-of-pocket maximum* for network services is $1,000 per person and $2,000 per family.

The following do not count toward the *out-of-pocket maximum*:

- *Non-notification penalties.*
- Cost of treatment subject to exclusions.

If you fail to *precertify* your care, you may be charged a *non-notification penalty*. The *non-notification penalty* for each type of service is listed in the Benefit Highlights chart on pages 87-88, and in the following descriptions of services.

Network Benefits

Outpatient Care - The *copayment* schedule for network outpatient *covered services* is shown below:

Visits 1-4 - *No copayment*

Visits 5 and over (individual) - $15 *copayment*

Visits 5 and over (group) - $10 *copayment*

Outpatient care *cross accumulates* with EAP services. (See page 91 for a full explanation of EAP services.) You have four sessions with no *copayment* for EAP, mental health, or substance abuse services.

Failure to *precertify* outpatient care results in a benefit reduction to the out-of-network level reimbursement, and in some cases, may result in no coverage. Please refer to the section titled **Out-of-Network Services** below for further details.

In-Home Care - In-home care is a *covered service* if *precertified*. Treatment that is *not pre-certified* but deemed to be a *covered service* receives out-of-network level reimbursement, and in some cases, may result in no coverage. Please refer to the section titled **Out-of-Network Services** below for further details.

Intermediate Care - *Intermediate care* is covered if *precertified*. This includes, but is not limited to, 24-hour *intermediate care* facilities (for example, residential treatment, group homes, halfway houses, therapeutic foster care, day/partial hospital, and structured outpatient treatment programs). *Intermediate care* that is not *precertified* but deemed to be a *covered service* receives out-of-network level reimbursement.

Inpatient Care - Network inpatient care deemed to be a *covered service* in a general or psychiatric hospital, or substance abuse facility if *precertified* is covered at 100% after a $200 per calendar quarter *deductible*. There is a $200 *non-notification penalty* for failure to *precertify* inpatient care.

Drug Testing - *Precertified* drug testing is covered as an adjunct to substance abuse treatment.

Substance Abuse Rehabilitation Incentive Program - Members who successfully complete all prescribed inpatient treatment and aftercare rehabilitation for substance abuse can apply for a refund for all inpatient and outpatient copays associated with their treatment.

Psychological Testing - Psychological testing, including neuropsychological testing, that is deemed to be a *covered service* is covered when *precertified*. Psychological testing that is not *precertified*, yet deemed to be a *covered service*, receives out-of-network level reimbursement.

Out-of-Network Services

Care from an *out-of-network provider* is paid at a lower level than network care. Out-of-network care is subject to *deductibles*, *copayments*, and *coinsurance*.

Benefits are paid based on *allowed charges* that are reasonable and customary fees or negotiated fee maximums, as determined by UBH. If your *out-of-network provider* or facility charges more than these *allowed charges*, you may be responsible for the difference, in addition to any amount not covered by the benefit.

Out-of-network mental health, and substance abuse treatment is subject to a $150 per person/ $300 per family calendar year *deductible*. Calendar year *deductible*s must be met prior to inpatient *deductibles* and *cross accumulate* between all out-of-network mental health and substance abuse benefit levels.

The *out-of-pocket maximum* for out-of-network care is $3,000 per member with no family maximum. The following do not count toward the *out-of-pocket maximum*:

- Out-of-network calendar year *deductibles*
- Out-of-network inpatient *deductibles*
- *Non-notification penalties*
- Cost of treatment found to not be a *covered service*
- Charges in excess of UBH's *allowed charges*

All out-of-network services must be *precertified* with UBH in order to be eligible for coverage. All out-of-network outpatient visits in a calendar year, including mental health, substance abuse and EAP outpatient visits, medication management visits and in-home mental health care visits, are accumulated to determine the appropriate out-of-network level of reimbursement. There is no longer a 15 visit per year maximum on out-of-network outpatient visits, but there are different levels of reimbursement for out-of-network outpatient visits 1-15 and visits 16 and over as described below. Also, all out-of-network outpatient visits after visit 15 must be *precertified* in order to be eligible for reimbursement. Charges paid by the covered person for out-of-network outpatient care, if determined to be a *covered service* and if *precertified* when required, do count toward the *out-of-pocket maximum*. If it is determined that care was not a *covered service*, no benefits will be paid.

Out-of-Network Benefits

Outpatient Care – Out-of-network outpatient visits 1 through 15, which are deemed to be *covered services,* are paid at 80% of UBH's *allowed charges*, after your $150 annual *deductible* is met. Outpatient visits 16 and over that are *precertified* are paid at 50% of UBH's *allowed charges*. Out-of-network outpatient visits 1 through 15 do not require *precertification*, however, all outpatient out-of-network visits beyond session 15 require *precertification* with a *UBH Clinician* (call UBH toll-free 1-888-610-9039). *C*harges paid by the covered person for outpatient out-of-network care for visits beyond session 15 that are not *precertified* do not count towards the *out-of-pocket maximum*.

In-Home Care – Included in outpatient care visits and accumulate with other outpatient visits to determine the appropriate out-of-network level reimbursement. Out-of-network outpatient visits up to session 15, which are deemed to be *covered services,* are paid at 80% of UBH's *allowed charges*, after the appropriate annual *deductible* has been met. Out-of-network outpatient visits beyond session 15 require *precertification*. *Precertified* out-of-network outpatient visits 16 and over are paid at 50% of UBH's *allowed charges.*

Intermediate Care - *Intermediate care,* which is deemed to be a *covered service,* is paid at 80% after the appropriate annual *deductible* has been met.

Inpatient Care - Inpatient care, which is deemed to be a *covered service* for mental health care or substance abuse treatment, is paid at 80% in a general hospital, psychiatric hospital or substance abuse facility.

Each admission to a hospital or facility is subject to a $150 inpatient *deductible* per person in addition to the calendar year *deductible*. Failure to *precertify* inpatient care is subject to a *non-notification penalty* of $200 if the UBH case manager determines that the care is a *covered service*. No benefits will be paid if it is found not to be a *covered service*.

Drug Testing - There is no coverage for out-of-network drug testing.

See pages 92-94 for a list of Exclusions.

Enrollee Assistance Program

The Enrollee Assistance Program can help with the following types of problems:

- Breakup of a relationship
- Divorce or separation
- Becoming a step-parent
- Helping children adjust to new family members
- Death of a friend or family member
- Communication problems
- Conflicts in relationships at work
- Legal difficulties
- Financial difficulties
- Child or elder-care needs
- Aging
- Traumatic events

To use your EAP benefit, call toll-free 1-888-610-9039 (TDD: 1-800-842-9489). The procedures for *precertifying* EAP care and referral to an EAP provider are the same as for mental health and substance abuse services. You will be referred by a *UBH clinician* to a trained EAP provider and/or other specialized resource (e.g., attorneys, family mediators, dependent care services) in your community. The *UBH clinician* may recommend mental health and substance abuse services if the problem seems to require more extensive help than EAP services can provide.

Legal Services

Legal assistance is available to enrollees of the Tufts Navigator Plan. UBH Legal Assistance services give you free and discounted, confidential access to local attorneys, who will answer legal questions, prepare legal documents, and help resolve legal issues. This service provides:

- Free referral to a local attorney
- Free 30 minute consultation (phone or in-person) per legal matter
- 25% discount for ongoing services
- Free online legal information, including common forms and will kits.

For more information or to be connected with UBH Legal Assistance call UBH toll free at 1-888-610-9039 (TDD 1-800-842-9489)

Employee Assistance Program

In addition, the Commonwealth offers an Employee Assistance Program as a resource to all agencies. All state employees can access critical incident debriefing services at no cost to the individual. Managers and supervisors can receive confidential consultations and resource recommendations for dealing with employee problems such as low morale, disruptive workplace behavior, mental illness, and substance abuse.

Network Benefits

EAP network benefits are paid according to the outpatient *copayment* schedule and *cross accumulate* with those benefits. No *copayment* is required for the first four visits, provided they have not been used for mental health and substance abuse care. If you use your first four visits as EAP sessions, all additional sessions for mental health and substance abuse services will be subject to the *copayment* schedule for outpatient treatment set forth on page 89.

Out-of-Network Benefits

There is no coverage for out-of-network EAP services.

What's Not Covered – Exclusions

The following exclusions apply regardless of whether the services, supplies, or treatment described in this section are recommended or prescribed by the covered person's provider and/or are the only available treatment options for the covered person's condition.

This benefit plan does not cover services, supplies or treatment relating to, arising out of, or given in connection with the following:

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM).

- Prescription drugs or over the counter drugs and treatments. See pages 48-52 in Part 5 of this *Member Handbook* for information on prescription drug coverage.

- Services or supplies for MHSA treatment that, in the reasonable judgment of UBH are any of the following:

    - not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance abuse;

    - not consistent with prevailing national standards of clinical practice for the treatment of such conditions;

    - not consistent with prevailing professional research demonstrating that the service or supplies will have a measurable and beneficial health outcome;

    - typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; or

    - not consistent with UBH's Level of Care Guidelines or best practices as modified from time to time.

UBH may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information.

- Unproven, Investigational or Experimental Services. Services, supplies, or treatments that are considered unproven, investigational, or experimental because they do not meet generally accepted standards of medical practice in the United States. The fact that a service, treatment, or device is the only available treatment for a particular condition will not result in it being a *Covered Service* if the service, treatment, or device is considered to be unproven, investigational, or experimental.

- Custodial Care except for the acute stabilization of the covered person and returning the covered person back to his or her baseline levels of individual functioning. Care is determined to be custodial when:

    - it provides a protected, controlled environment for the primary purpose of protective detention and/or providing services necessary to assure the covered person's competent functioning in activities of daily living; or

- it is not expected that the care provided or psychiatric treatment alone will reduce the disorder, injury or impairment to the extent necessary for the covered person to function outside a structured environment. This applies to covered persons for whom there is little expectation of improvement in spite of any and all treatment attempts; or

- covered persons whose repeated and volitional non-compliance with treatment recommendations result in a situation in which there can be no reasonable expectation of a successful outcome.

- Neuropsychological testing for the diagnosis of attention deficit disorder.

- Examinations or treatment, unless it otherwise qualifies as Behavioral Health Services, when:

  - required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption;

  - ordered by a court except as required by law;

  - conducted for purposes of medical research; or

  - required to obtain or maintain a license of any type.

- Herbal medicine, holistic or homeopathic care, including herbal drugs, or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

- Nutritional counseling, except as prescribed for the treatment of primary eating disorders as part of a comprehensive multimodal treatment plan.

- Weight reduction or control programs (unless there is a diagnosis of morbid obesity and the program is under medical supervision), special foods, food supplements, liquid diets, diet plans or any related products or supplies.

- Services or treatment rendered by unlicensed providers, including pastoral counselors (except as required by law), or which are outside the scope of the providers' licensure.

- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, computers, beauty/barber service, exercise equipment, air purifiers or air conditioners.

- Light boxes and other equipment, including durable medical equipment, whether associated with a behavioral or non-behavioral condition.

- Private duty nursing services while confined in a facility.

- Surgical procedures including but not limited to gender reassignment operations.

- Smoking cessation related services and supplies.

- Travel or transportation expenses unless UBH has requested and arranged for the covered person to be transferred by ambulance from one facility to another.

- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

- Services performed by a provider with the same legal residence as the covered person.

- Behavioral health services for which the covered person has no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the benefit plan.

- Charges in excess of any specified benefit plan limitations.
- Any charges for missed appointments.
- Any charges for record processing except as required by law.
- Services provided under another plan and services or treatment for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or a similar law is optional because the covered person could elect it or could have it elected for him or her, benefits will not be paid if coverage would have been available under the workers' compensation or similar law had that coverage been elected.
- Behavioral Health Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country when the covered person is legally entitled to other coverage.
- Treatment or services received prior to the covered person being eligible for coverage under the Plan or after the date the covered person's coverage under the Plan ends.

Index

This index lists the major benefits and limitations of the Navigator plan. Of course, it does not list everything in this *Member Handbook*. To fully understand all benefits and limitations, a *Member* must read through this *Member Handbook* carefully.

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Need to Write or Call?

Tufts Health Plan
705 Mt. Auburn Street, P.O. Box 9173
Watertown, MA 02471-9173

1-800-870-9488

For the Enrollee Assistance Program or
Mental Health or Substance Abuse treatment,
please call United Behavioral Health

1-888-610-9039

Commonwealth of Massachusetts
Group Insurance Commission

NAVIGATOR
by TUFTS Health Plan

Tufts Health Plan
333 Wyman Street, P.O. Box 9112
Waltham, MA 02454-9112

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